

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|--|---------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jacob A Adams | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 30 83 | | 2b. HOUR 7:50 PM |
| 3. SEX Male | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 4 27 18 | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MARYLAND | 13b. COUNTY A.A. | 13c. CITY OR TOWN ANNAPOLIS | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 379 Forest Beach Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HEZEKIAH | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIET I. ANDERSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-0820 | | 17. INFORMANT ADDRESS LUCILLE ADAMS 379 Forest Beach Rd. Annapolis, Md. 21401 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lung Cancer

1629

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/5 19 83 to 12/30 19 83, that (I) (we) last saw the deceased alive on 12/30 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE E W Cole | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 12/31/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE | | 22e. ADDRESS 57 FRANKLIN ANNAPOLIS Md. | |

| | | | |
|---|-----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 1-5-1984 | 23c. NAME OF CEMETERY OR CREMATORY ASBURY BROADNECK CHURCH | 23d. LOCATION CITY OR TOWN COUNTY STATE St. Margarets A.A. Maryland |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1984 | |
| | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

Mr. [Name] [Address]

Dear Sir:

I am writing to you regarding the [Topic] [Details]

I am writing to you regarding the [Topic] [Details]

I am writing to you regarding the [Topic] [Details]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Edna Mary Adelman</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>12 24 83</i> | | 2b. HOUR <i>3¹⁰ AM</i> |
| 3. SEX <i>female</i> | 4. RACE <i>white</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>10 29 97</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington DC</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>AA Co</i> M.D. | | |
| 10. CITY OR TOWN OF DEATH <i>Edgewater</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pleasant Living Conv. Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | 13b. COUNTY <i>Anne Arundel</i> | 13c. CITY OR TOWN <i>Edgewater</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <i>902 Fortune Place 21037</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert Blake</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Thompson</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>578- 07-5620D</i> | 17. INFORMANT ADDRESS <i>Robert F. Adelman (same as 13e)</i> | | | |

| | | | | | |
|--|--|---|--|-------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/23</i> , 19 <i>82</i> , to <i>12/24</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>12/22/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Charles W. Kinser</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>12/24/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles W. Kinser</i> | | 22e. ADDRESS <i>16 Murray Avenue, Annapolis, Maryland</i> | | | |

| | | | |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>12-27-83</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arlington Virginia</i> |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Beall Funeral Home 16000 Annapolis Road Bowie, Maryland</i> | | 25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1983</i> | 25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i> |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS LAVINIA ADKINS | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1983 | | 2b. HOUR 533 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5 22 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 24 HRS. HOURS MIN. 533 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY Metal | | | | | |
| 13a. STATE Md. | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 7873 Crilley Road 21061 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elmer Jones | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-01-5892 | | 17. INFORMANT Ms. Nadine Hall | | ADDRESS 2102 Ohio Ave. Balto., Md. 21227 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) SHOCK - SEPTIC DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE, RENAL FAILURE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/83 to 12/24/83 , that (I) (we) lost saw the deceased alive on 12/24/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Surya P. Mundra</i> | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/24/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURYA P. MUNDRA, M.D. | | | | 22e. ADDRESS 203 EAST PATAPSCO AVENUE BALTIMORE, MARYLAND 21225 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 12/24/83 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | | | 25. DATE RECEIVED BY REGISTRAR JAN 5 1984 | | | | | |

503 EAST PATRICK AVENUE

BALTIMORE, MARYLAND 21225

SIRYA F. MARRA, M.D.

Handwritten signature

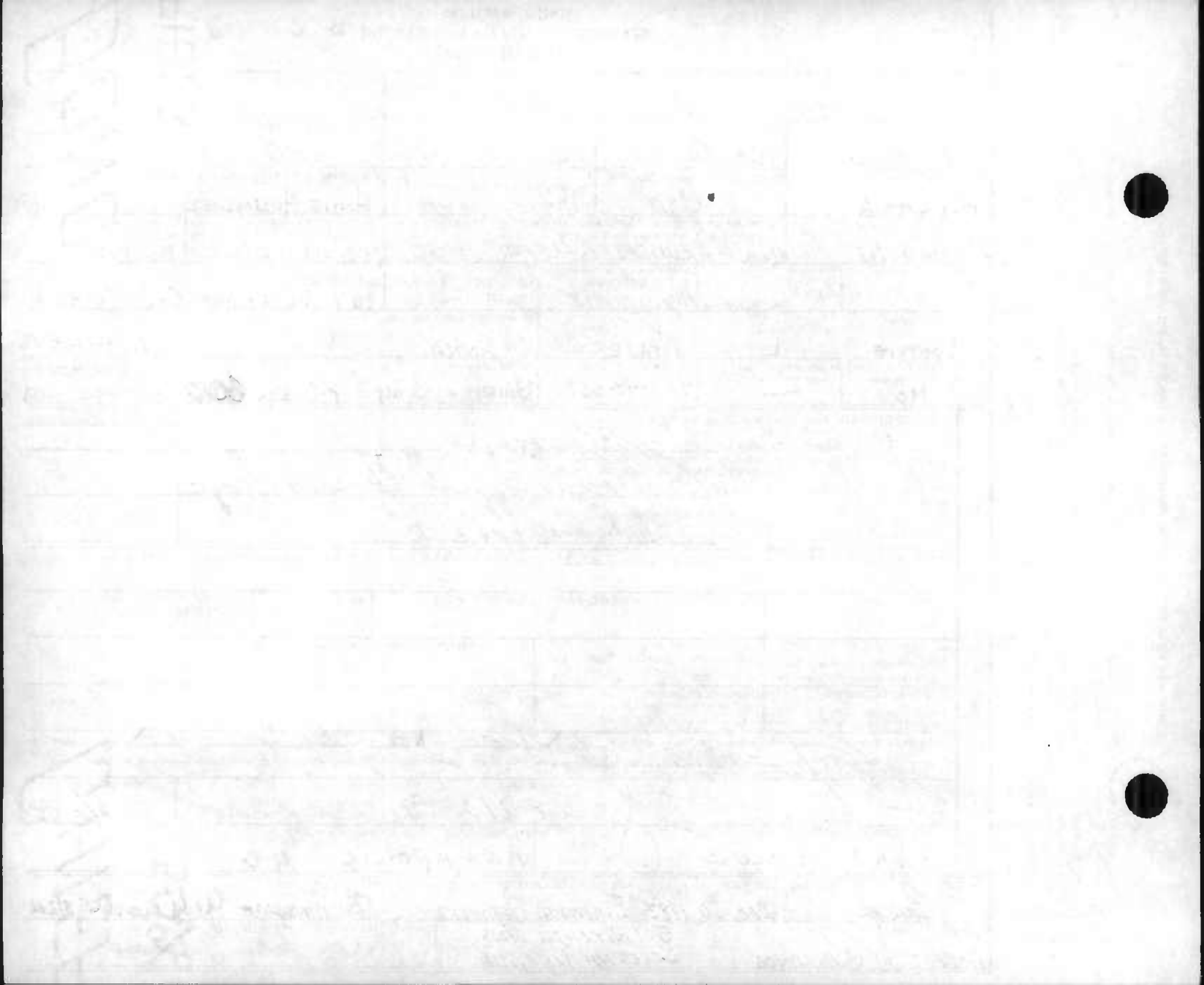
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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 83 31527 | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| | | Pearl W Allen | | 12 26 83 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Female | | White | | 3 27 01 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS | |
| ALABAMA | | USA | | 83 | |
| 8. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| ANNAPOLIS | | ANNE ARUNDEL GENERAL HOSP. | | ANNE ARUNDEL MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | |
| MD | | ANNE ARUNDEL Annapolis | | 107 MERRYMAN Ct. 21401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| LONNIE L. WALTERS | | ANNA E. LAULER | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17a. ADDRESS | |
| 417-44-6671 | | SHIRLEY SIMI | | 21401 P.O. Box 6012 ANNAPOLIS MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Hypertension | | | | | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Hemorrhage | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 25 Dec 1983, to 26 Dec 1983, that (1) I saw the deceased alive on 26 Dec 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| John Lowe | | ATTENDING PHYSICIAN | | 26 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| John Lowe | | ANNAPOLIS MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Dec. 30, 1983 | | ELMWOOD CEMETERY | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert S. Barranca | | DEC 30 1983 | | John J. Barranca | |

BP



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8331528

1- FOR
STATE
REGISTRAR

Eliel W. Armiger

REG. NO.

| | | | | | | |
|--|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) ARMIGER, ELIEL | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-2-83 | | 2b. HOUR 3:55 AM | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR January 10, 1885 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS 00 00 | | 8. UNDER 24 HRS. HOURS MIN. 00 00 | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITIZEN OF WHAT COUNTRY? USA | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. CITY OR TOWN OF DEATH Edgewater | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Nursing Home | | 14. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland | | 15b. COUNTY Calvert | | 15c. CITY OR TOWN Dunkirk | | |
| 16. FATHER'S NAME FIRST MIDDLE LAST Jospeh R. Armiger | | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret C. unk | | 18. STREET ADDRESS 6034 McKendree Rd. 20754 | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 20. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a | | 21. INFORMANT ADDRESS Virginia Dove - same as #13 | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Prostate Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Coronary Artery Disease; Congestive Heart Failure | | | | | | |
| 23. DATE OF OPERATION | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 25. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 27. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 30. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 32. LOCATION STREET CITY OR TOWN COUNTY STATE | | 33. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | |
| 34. SIGNATURE Charles W. Kinzer | | 35. DEGREE MD | | 36. DATE SIGNED 12-2-83 | | |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT) Charles William Kinzer | | 38. ADDRESS | | | | |
| 39. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 40. DATE Dec. 3, 1983 | | 41. NAME OF CEMETERY OR CREMATORY Smithville | | |
| 42. FUNERAL DIRECTOR NAME John O. Rausch | | 43. ADDRESS PO Box 45 Annapolis, Md. | | 44. DATE REC'D. BY REGISTRAR DEC 9 1983 | | |
| 45. REGISTRAR'S SIGNATURE John J. Conner | | 46. LOCATION Dunkirk Calvert Maryland | | | | |

BP _____

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

| SECTION 16 | | TOWNSHIP 36N | | RANGE 12E | |
|------------|----|--------------|----|------------|----|
| ACRES | | MORPHOLOGY | | VEGETATION | |
| 1 | 10 | 1 | 10 | 1 | 10 |
| 2 | 10 | 2 | 10 | 2 | 10 |
| 3 | 10 | 3 | 10 | 3 | 10 |
| 4 | 10 | 4 | 10 | 4 | 10 |
| 5 | 10 | 5 | 10 | 5 | 10 |
| 6 | 10 | 6 | 10 | 6 | 10 |
| 7 | 10 | 7 | 10 | 7 | 10 |
| 8 | 10 | 8 | 10 | 8 | 10 |
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| 12 | 10 | 12 | 10 | 12 | 10 |
| 13 | 10 | 13 | 10 | 13 | 10 |
| 14 | 10 | 14 | 10 | 14 | 10 |
| 15 | 10 | 15 | 10 | 15 | 10 |
| 16 | 10 | 16 | 10 | 16 | 10 |
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| 18 | 10 | 18 | 10 | 18 | 10 |
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| 21 | 10 | 21 | 10 | 21 | 10 |
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| 47 | 10 | 47 | 10 | 47 | 10 |
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| 49 | 10 | 49 | 10 | 49 | 10 |
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| 53 | 10 | 53 | 10 | 53 | 10 |
| 54 | 10 | 54 | 10 | 54 | 10 |
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| 90 | 10 | 90 | 10 | 90 | 10 |
| 91 | 10 | 91 | 10 | 91 | 10 |
| 92 | 10 | 92 | 10 | 92 | 10 |
| 93 | 10 | 93 | 10 | 93 | 10 |
| 94 | 10 | 94 | 10 | 94 | 10 |
| 95 | 10 | 95 | 10 | 95 | 10 |
| 96 | 10 | 96 | 10 | 96 | 10 |
| 97 | 10 | 97 | 10 | 97 | 10 |
| 98 | 10 | 98 | 10 | 98 | 10 |
| 99 | 10 | 99 | 10 | 99 | 10 |
| 100 | 10 | 100 | 10 | 100 | 10 |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST <i>Frances Louise Myers</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>12 27 83</i> | | 2b. HOUR <i>8:30</i> M | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Cauc.</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>6-9-1916</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>67</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County, MD.</i> | |
| 10. CITY OR TOWN OF DEATH <i>Glen Burnie</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Maryland Manor Con. Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>-</i> | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>A.A.</i> | | 13c. CITY OR TOWN <i>Pasadena</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry H. Power</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nannie M. Skinner</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i> | | | |
| | | 16b. SOCIAL SECURITY NO. <i>228-28-1473</i> | | 17. INFORMANT ADDRESS <i>Rachel Andre 320 Bar Harbor Rd.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4275 Cardio-Pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Michael Pearlman</i> | | 22e. ADDRESS <i>5400 Old Court Rd. - Baltimore, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>12-30-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore - Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Raymond C. Fink Glen Burnie, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>DEC 29 1983</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MEMORANDUM

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

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Item 2b., 591, 5/9/84, by F.H., Gbj

STATE OF MARYLAND

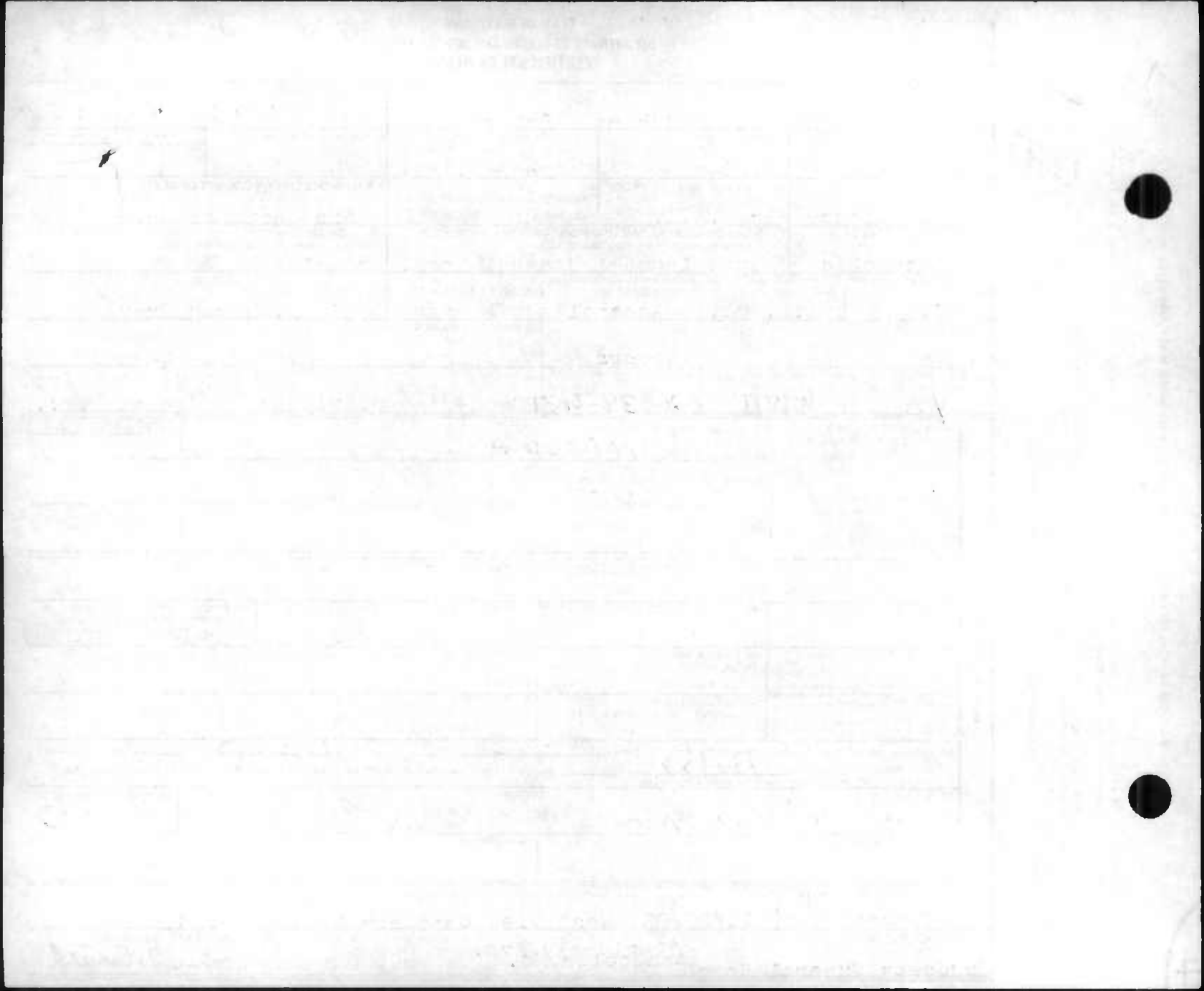
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank Hubert Babers | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/23/83 | | 2b. HOUR 10:05 P. |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR June 26, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 79 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ft Pierce Fla | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) chemist | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. | 13c. COUNTY A.A. Co. | 13d. CITY OR TOWN Annapolis | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13f. STREET ADDRESS 215 S. Cherry Grove | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Babers | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fanny Hunter Babers | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 026-34-0637 | | 17. INFORMANT ADDRESS 111 Virginia Ave. Edgewater, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOMA 2028 DUE TO, OR AS A CONSEQUENCE OF (b) CVA Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19____, to 12/23/83 , 19____, that (I) (we) last saw the deceased alive on 12/21/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE | | 22c. DATE SIGNED 12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12/23/83 | 23c. NAME OF CEMETERY OR CREMATORY West View Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | 12. ADDRESS 12 Ridgely Ave. Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|--------------------------|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2b. DATE ESTIMATED OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH (MONTH DAY YEAR) | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | |
| Male | | White | | May 29 52 | | 26 YRS. | | | | December 21 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Anne Arundel | | MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Glen Burnie | | North Arundel | | | | Stylist Barber | | Barber Shop | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| md | | AA | | Linthicum | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 714 Camp Meade Rd. | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | | | | |
| Silas E. Baldwin | | | | Ellen R. Collison | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | None | | 216.70.2802 | | Ellen R. McDermott | | Pikesville MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head TRAUMA</u> 9289 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Motor Vehicle Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE) | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>William P. Jones</u> | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER DATE SIGNED 12-21-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | | | ADDRESS 695 America Ct. Davidsonville 21035 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Dec. 24, 83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem | | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Brooklyn Park A.A. MD | | | |
| 24. FUNERAL DIRECTOR NAME <u>H. B. Jones</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | 25b. REGISTRAR'S SIGNATURE <u>J. J. Smith</u> | | | |
| Singleton Funeral Home, Glen Burnie, MD | | | | | | | | | | | |

STANDARD TELEPHONE & TELEGRAPH CO. OF NEW YORK

7
To: Mr. J. B. ...
From: Mr. J. B. ...

Re: ...
Date: ...

Very truly yours,
J. B. ...

Enclosed ...

Very truly yours,
J. B. ...

100-1000
100-1000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 3 2

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William T. Ballantine | | | 2a. DATE OF DEATH MONTH DAY YEAR December 25, 1983 | | 2b. HOUR 8:54 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 29, 1910 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Planner | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Guard | | 13. STREET ADDRESS 404 Frankle Street (21225) | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Ballantine | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Dunn | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | |
| 16b. SOCIAL SECURITY NO. 220 05 2232 | | 17. INFORMANT Margaret A. Ballantine | | ADDRESS same as 13 e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Aortic Aneurysm</i> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i> 5 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Atherosclerosis</i> 10 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 sec | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-7-77</i> , 19 <i>83</i> , to <i>12-25</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12-22</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death. | | | | | | |
| 22b. SIGNATURE <i>Benjamin Berdann</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12-27-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN BERDANN | | 22e. ADDRESS 606 Hammond Lane | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/29/83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md. | | 24. FUNERAL DIRECTOR NAME George J. Gonce | | 25. DATE REC'D. BY REGISTRAR DEC 27 1983 | | |
| 24. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy | | 25. REGISTRAR'S SIGNATURE <i>John J. Canine</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

Washington, D. C., September 11, 1911

Mr. J. H. ...

Dear Sir:

I have received your letter of the 10th inst.

and am glad to hear that you are interested in the

work of the Bureau of Plant Industry.

I am, very respectfully,

Yours very truly,

W. L. ...

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8 3 3 1 5 3 3

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Marian | | MIDDLE C | | LAST Ballard | | 2a. DATE OF DEATH MONTH DAY YEAR | | 12 2 83 | | 2b. HOUR 12 ¹⁰ P.M. | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR | | 11 17 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 74 YRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Cty MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY Legal | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN Edgewater | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 101 Park Ave. 21037 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Cavallaro | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Cocimano | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) — | | 17. INFORMANT Joseph Cocimano | | ADDRESS 6109 Auth Road Camp Spring, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Hepatic failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastatic liver disease (c) Adenocarcinoma of colon | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20146 3 wk 2 mos 8 mos | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Upper gastrointestinal bleeding | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 83, to Dec 2 19 83, that (I) (we) last saw the deceased alive on Dec 2 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | |
| 22b. SIGNATURE Michael N. Peters M.D. | | 22c. DATE SIGNED 12/2/83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael N. Peters | | 22e. ADDRESS 2510 Riva Rd. Annapolis, MD 21401 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 5, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Lakemont | | 23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville AD MD | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis MD | | 25a. DATE REC'D. BY REGISTRAR DEC 2 1983 | | 25b. REGISTRAR'S SIGNATURE D. C. C. C. | | | | | | | | | |

19

THE UNIVERSITY OF CHICAGO
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 3 4

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|--|---------------------------------------|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances O. Barber | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec 26, 1983 | | | 2b. HOUR M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct 11, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 83 | | 7. UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 113 Severn Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 113 Severn Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Cranford | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Wilson | | | ADDRESS 1050 Eaglewood Rd Annapolis MD 21403 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219543837 | | | 17. INFORMANT Helen Myers - Annapolis MD 21403 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac Death 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Severe, known Coronary Art. Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ① Severe COPD ② Huge, inoperable abd. aortic aneurysm. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Peter F. Verkouw | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/27/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUW | | | | | | 22e. ADDRESS 1419 FOREST DR. Annapolis MD 21403 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Dec 28, 1983 | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1983 | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 of this certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "label" and "X" are visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "X" and "label" are visible.

HP
DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 83 31535 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLOREAN F. BARNES | | | | 20. DATE OF DEATH MONTH DAY YEAR 12-26-83 | | | |
| 2. SEX FEMALE | | 3. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 18 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Edgewater, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Conv. Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical | | 12b. KIND OF BUSINESS OR INDUSTRY Paper Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Baltimore | | 13c. CITY OR TOWN Lansdowne | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 628 Washington Ave. 21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charlie T. Foster | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude M. Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 226-03-2903 | | 17. INFORMANT ADDRESS Thomas M. Barnes 628 Washington Ave. 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) Cancer of Pancreas DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Charles W. Kimer | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kimer | | | | 22e. ADDRESS Pleasant Living Conva. Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | | | 24. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229 | | 25. DATE REC'D. BY REGISTRAR DEC 28 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Carried | | | |

NOTES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|---|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EST | |
| I. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| ADEMIA BARTOLETTI | | | | DECEMBER 16, 1983 3:02 P.M. | |
| 3. SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Female | White | April 29 1898 | | 85 YRS | |
| 7a. BIRTHPLACE COUNTRY | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| Italy | USA | | | ANNE ARUNDEL COUNTY MD. | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Housewife | | Household |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | AACo | Crownsville | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1137 Plum Dr. 21032 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| John Bottega | | Carmela Fonzi | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 212-74-9048 | | Carmela Arbogast Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock & MI</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CADx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>5 years</u> <u>years</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> 19 <u>83</u> , to <u>12/16</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | 22b. SIGNATURE <u>David G. Schwartz</u> | | 22c. DATE SIGNED <u>12/16/83</u> | |
| 22d. PHYSICIAN'S NAME | | 22e. ADDRESS | | | |
| DAVID G. SCHWARTZ, D.O. | | 7845 OAKWOOD ROAD #200 GLEN BURNIE, MD. 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 12-20-83 | | Our Lady of the Field | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Hardesty Funeral Home | | Annapolis, Md. | | DEC 22 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Baniel</u> | |

MEDICAL CERTIFICATION



ACEMIA

BARTOLITTI

DECEMBER 16, 1963 3:02

ANNIS ARUNDEL COUNTY

WORTH ARUNDEL HOSPITAL

OLEN BURNIE

7845 ORKWOOD ROAD 4500
OLEN BURNIE, MD. 21001

DAVID A. SCHWARTZ, D.O.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth M. Bents | | | | | 2a. DATE OF DEATH MONTH DAY YEAR December 22, 1983 | | | 2b. HOUR 9:16 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 29, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD. | | | |
| 10. CITY OR TOWN OF DEATH Severna Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Ctr. Severna Pk | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-wife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY - 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 508 S. Madeira St. 71231 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Christopher - Riesner | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa - ? unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 217-18-1053 | | 17. INFORMANT ADDRESS Elizabeth Weatherstein, 760, 208th Street. Pasadena, Md. 21122 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed. Immed. Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) anemia, hyperkalemia | | | | | | | | | |
| 19a. DATE OF OPERATION 12/23/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED hysterectomy | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 115 83 12/22 83 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/5 , 19 83 , to 12/22 , 19 83 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dr. Ira Kaplan | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ira Kaplan | | | | 22e. ADDRESS 7845 Oakwood Rd./ Glen Burnie, Md. 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, - , Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave./21231 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canine | | | |

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(U) [REDACTED] [REDACTED] [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | REG. NO. | |
|--|--|--|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Vincent A Birch | | | | | 2a. DATE OF DEATH MONTH 12 DAY 18 YEAR 83 | | 2b. HOUR 3:45 P.M. |
| 3. SEX M | 4. RACE White | 5. DATE OF BIRTH MONTH 1 DAY 16 YEAR 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash.D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) pressman | | 12b. KIND OF BUSINESS OR INDUSTRY Govt. printing |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 618 Charles Ave. 20757 | |
| 13a. STATE Md. | 13b. COUNTY A.A. Co. | 13c. CITY OR TOWN Deale | | | | | |
| 14. FATHER'S NAME FIRST clarence MIDDLE LAST Birch | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ellen LAST Hardy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 265-54-6213 | | 17. INFORMANT Marjory Birch | | ADDRESS 618 Charles Ave. Deale, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ventricular dysfunction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Acute Inferior myocardial infarction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) coronary dysfunction | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18 19 83 to 12/18 19 83 , that (I) (we) last saw the deceased alive on 12/18 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE George C. Samaras | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/18/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras | | 22e. ADDRESS 205 Ridgely Ave Ann. Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/21/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Md. PG Co. | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | ADDRESS Ann. Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canier | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | WOODROW LEE BITZER | | DECEMBER 16, 1983 | | 736 PM | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR March 20 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Wagners | | 12b. KIND OF BUSINESS OR INDUSTRY Service Center | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. STREET ADDRESS 934 Riverside Drive 21122 | |
| 14. FATHER'S NAME Lee | | 15. MOTHER'S MAIDEN NAME Cora Uhler | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 216-09-4367 | |
| | | | | 17. INFORMANT Mrs. Catherine Bitzer | | ADDRESS 934 Riverside Drive Highpoint-Pasadena 21122 | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Obstructive Pulmonary disease</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| | | 19a. DATE OF OPERATION | | | | | |
| | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>81</u> to <u>12/16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Glenn F. Robbins</u> | | DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN F. ROBBINS, M.D. | | 22e. ADDRESS 1404 CRAIN HIGHWAY GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore Maryland | |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133 | | 25. DATE RECEIVED BY REGISTRAR DEC 20 1983 | | 26. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | | | |



UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

REPORT OF INVESTIGATION
DATE: 10/10/68
TO: SAC, NEW YORK
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

[Illegible text follows in several lines]

[Illegible text follows in several lines]

1001 GRAND AVENUE
NEW YORK, N.Y. 10017

CLERK: [Illegible]
SPECIAL AGENT IN CHARGE: [Illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE B. BLAKE | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-9-83 | | 2b. HOUR 6:35 P.M. | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 1-20-16 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ANNE ARUNDEL GENERAL HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 21403 | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLIE DORSEY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH HILLARY | | 16. STREET ADDRESS 1161 Eastport Terrace | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 213124696 | | 17. INFORMANT ADDRESS DELIA CHEW 1434 Tyler Ave. Annapolis, Md. 21403 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4960 ACUTE RESPIRATORY FAILURE IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF CHRONIC OBSTRUCTIVE LUNG DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) } PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/9/83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/4/83 to 12/9/83 , that (I) (we) lost saw the deceased alive on 12/9/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Donald C. Roane | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/9/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald C. Roane, M.D. | | 22e. ADDRESS 1616 Forest Drive Annapolis | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-14-1983 | | 23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | |
| 24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | |
|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 |
| 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 |
| 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 |
| 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 |
| 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 |
| 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 |
| 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is equivalent to a certain boundary value problem for a certain class of functions. This problem is then solved by the method of separation of variables. The solution is then used to find the values of the various quantities of interest.

2. In the second part of the paper, the results of the first part are used to find the values of the various quantities of interest. It is shown that the values of these quantities are given by certain definite integrals. These integrals are then evaluated by the method of residues. The results are then compared with the results of other workers in the field.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Goldie A. Blockinger | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 27, 1983 | | 2b. HOUR 12⁰⁰ P.M. | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 - 24 - 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN V. R. SHECKELS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA COLEMAN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 214-30-4331 | | 17. INFORMANT ADDRESS MARLYN J. ELLIS (SAME AS 13) | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Breast cancer

APPROXIMATE INTERVAL

13 years

1749
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 70</u> to <u>12</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12/27</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Stuart E. Selonick, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D. | | | | 22e. ADDRESS AA Gen. Hospital Franklin St. Annapolis, Md. | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE Dec. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL ANNE ARUNDEL MD. | |
| 24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO | | | | 25a. DATE REC'D. BY REGISTRAR DEC 30 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 4 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Paul S. Bosley. | | | 2a. DATE OF DEATH MONTH DAY YEAR December 10, 1983 | | 2b. HOUR M AM |
| 3. SEX Male. | 4. RACE Cau. | 5. DATE OF BIRTH MONTH DAY YEAR Sept 27, 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH AA MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman. | | 12b. KIND OF BUSINESS OR INDUSTRY Smith Pie Co. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 8104 High Point Rd. |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jefferson D. Bosley. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine F. Gill. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Yes. | | 16b. SOCIAL SECURITY NO. 213-03-4109 | | 17. INFORMANT ADDRESS Lillian O. Bosley. 8104 High Point Rd. | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4960 DUE TO, OR AS A CONSEQUENCE OF COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4960 DUE TO, OR AS A CONSEQUENCE OF Pneumonia (c) 4960 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr + 1 day YRS 1 wk |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9/83 , 19____, to 12/10/83 , 19____, that (I) (we) last saw the deceased alive on 12/9/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE E. J. Zulken M.D. | | DEGREE | | 22c. DATE SIGNED 12/12/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Folkner | | 22e. ADDRESS Mary Hosp. Balto. | | | |

| | | | |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial. | 23b. DATE Dec. 13, 1983 | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS Paul E. Chenoweth 3617 Chestnut Ave. Balto. Md. | | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1983 |
| | | | 25b. REGISTRAR'S SIGNATURE John J. Connelley |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

December 13, 1963

Mr. J. J. ...

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Best 27, 1963

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES E. BRADSHAW | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 7, 1983 | | 2b. HOUR 1:40P M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR December 1, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Crisfield, Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk | 12b. KIND OF BUSINESS OR INDUSTRY B. G & E | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY AA | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fletcher Morris | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary K. Franklin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-07-7491 | | 17. INFORMANT Richard C. Bradshaw, son, same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE 5845 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE TUBULAR NECROSIS OF KIDNEYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) SEPTICEMIC SHOCK | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS 36 HRS 48 HRS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): MESENTERIC VENOUS THROMBOSIS | | | | | |
| 19a. DATE OF OPERATION 12-5-83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-5 19 83 to 12-7 19 83 , that (I) (we) lost saw the deceased alive on 12-7 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE ADOLFO G. TORRES, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 12-7-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADOLFO G. TORRES, M.D. | | 22e. ADDRESS 7845 OAKWOOD ROAD, #201 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9 Dec. 83 | 23c. NAME OF CEMETERY OR CREMATORY Sunny Ridge Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield, Somerset, Md. | |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Maryland | | 25a. DATE REC'D. BY REGISTRAR DEC 9 1983 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

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JAN 10 1964



CLIFTON

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 4 4

1 - FOR
STATE
REGISTRAR

REG. NO.

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| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LOTTIE A. BRISCOE | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 18, 1983 | | 2b. HOUR 1:15A M |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 10 21 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | | 13b. COUNTY AA | 13c. CITY OR TOWN Severn | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Milton L Oden | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Susan | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS Gertrude Dailey - 508 Jones Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Breast Cancer 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 83 , to 12/18 , 19 83 , that (I) (we) lost saw the deceased alive on 12/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Philip Konits | | DEGREE | | 22c. DATE SIGNED 12/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHILIP H. KONITS, M.D. | | 22e. ADDRESS 615 HAMMONDS LANE BALTIMORE, MARYLAND 21225 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (APPROXY) Cremial | 23b. DATE 12/22/83 | 23c. NAME OF CEMETERY OR CREMATORY St Rest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Homewood AA Md | |
| 24. FUNERAL DIRECTOR NAME Turnell B Oden - Balto. Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 21 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Gough | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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CHIEF MAN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---------------------------|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Gordon Quinton Brooks | | | 2a. DATE KNOWN OF DEATH MONTH 12 DAY 7 YEAR 83 | | 2b. HOUR 1308 |
| 3. SEX M | 4. RACE CAU | 5. DATE OF BIRTH MONTH 4 DAY 23 YEAR 32 | 6. AGE (IN YEARS) 51 YRS. | IF UNDER 1 YR. MONTHS _____ DAYS _____ | IF UNDER 24 HRS. HOURS _____ MIN. _____ |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County | | 10. CITY OR TOWN OF DEATH Glen Burnie | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | 13b. COUNTY AA. | 13c. CITY OR TOWN Millersville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 5386 Brookwood Rd. | |
| 14. FATHER'S NAME FIRST Ross MIDDLE _____ LAST Brooks | | 15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE _____ LAST Shuler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. Korea | | 17. INFORMANT Bobby Brooks, Robbinsville, N. C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE William P. Jones | | TITLE (SPECIFY) Deputy | | DATE SIGNED 7 Dec 83 | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | ADDRESS 695 America Ct Davidsonville 21035 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10 Dec 83 | | 23c. NAME OF CEMETERY OR CREMATORY Old Mother Cemetery | |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley | | ADDRESS Glen Burnie Maryland | | 25a. DATE REC'D. BY REGISTRAR DEC 9 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Conish | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Evelyn Brown | | | 2a. DATE OF DEATH MONTH 12 DAY 8 YEAR 83 | | 2b. HOUR 11:25 AM |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH 6 DAY 22 YEAR 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. General | | 12a. USUAL OCCUPATION (NIGHT WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Annapolis | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST Cernell MIDDLE Brown LAST Brown | | | 15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE Gray LAST Gray | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-34-1409A | | 17. INFORMANT ADDRESS 81 W. Wash. St. Richard E. Brown - Anna, Md. 21401 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown DUE TO, OR AS A CONSEQUENCE OF (c) Unknown DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe hypertension, Heart failure, Pathologic obesity. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 22 , 19 83 , to Dec 8 , 19 83 , that (I) (we) last saw the deceased alive on Dec 8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Charles W. Kinzer | | DEGREE Attending Physician | | 22c. DATE SIGNED Dec 9, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer, M.D. | | 22e. ADDRESS Annapolis, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY Pine Lawn Mem. Pk. Annapolis | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE A.A. Md. | | 24. FUNERAL DIRECTOR NAME William Reese + Sons Mortuary | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | |
| 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31541

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM L BROWN | | 2a. DATE OF DEATH MONTH 12 DAY 7 YEAR 83 | | 2b. HOUR 8 A.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 7 DAY 26 YEAR 09 | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundle MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Insurance adjuster | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Churchton | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST late William L Brown Sr. MIDDLE late LAST late | | 15. MOTHER'S MAIDEN NAME FIRST late Ebbel M Harris MIDDLE late LAST late | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 578 01 8973 | | 17. INFORMANT Mrs EDith Brown |
| | | ADDRESS 5533 Gloucester St | | 20833 Md. |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Metastatic Colon Carcinoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET 12/5 | CITY OR TOWN 12/7 COUNTY 83 STATE |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/5 19 83 , to 12/7 19 83 , that (1) (we) last saw the deceased alive on 12/6 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE E W COLETH | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLETH | | 22e. ADDRESS 51 FRANKLIN ANNAPOLIS MD 21401 | |

| | | | |
|---|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Dec 10, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Crestlawn | 23d. LOCATION CITY OR TOWN Howard County COUNTY Howard STATE |
| 24. FUNERAL DIRECTOR NAME Harry H Witzke ADDRESS 4112 Columbia Ellicott City | | 25a. DATE REC'D BY REGISTRAR DEC 12 1983 | 25b. REGISTRAR'S SIGNATURE John L. Smith |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

Harry H Wicks 4112 Columbia Ellicott City
Burial Dec 10, 1923 Chestnut

Howard County

No 578 01 8973 Mrs Helen Brown 5233 Gloucester St Churchton
late William B Brown Sr.
late Ethel M Harris

Maryland AnneArundel Churchton
5233 Gloucester St 20833

Annapolis Anne Arundel General Hospital
Retired Insurance adjuster

Washington D.C. U.S.A. X
Anne Arundel

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 4 8

1. FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES WILLIS BRUCE | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 7, 1983 | | | 2b. HOUR 545 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 27, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Emp. (Ret.) | | 12b. KIND OF BUSINESS OR INDUSTRY Hardware | |
| 13a. STATE Maryland | | | | 13b. COUNTY Anne | | 13c. CITY OR TOWN Linthicum | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James A. Bruce | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie E. O'Rear | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT (wife) Mrs. Gay L. Bruce (same as # 13) | | ADDRESS | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Cardiomyopathy of Lung, Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General Debility</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Thoracic Acute Pneumonia

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>11-10</u> 19 <u>83</u> , to <u>12-7</u> 19 <u>83</u> , that (if we) lost saw the deceased alive on <u>12-6</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Edward Sherman | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12-7-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Sherman | | | | 22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BOULEVAR GLEN BURNIE, MARYLAND 21061 | | | |

| | | | | | | | |
|--|--|-------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10 Dec. 83 | | 23c. NAME OF CEMETERY OR CREMATORY Centuries Memorial Shreveport | | 23d. LOCATION CITY OR TOWN COUNTY STATE Louisiana | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie, MD | | | | 25a. DATE REC'D. BY REGISTRAR DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canier | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 4 9

1. FOR
STATE
REGISTRAR

REG. NO.

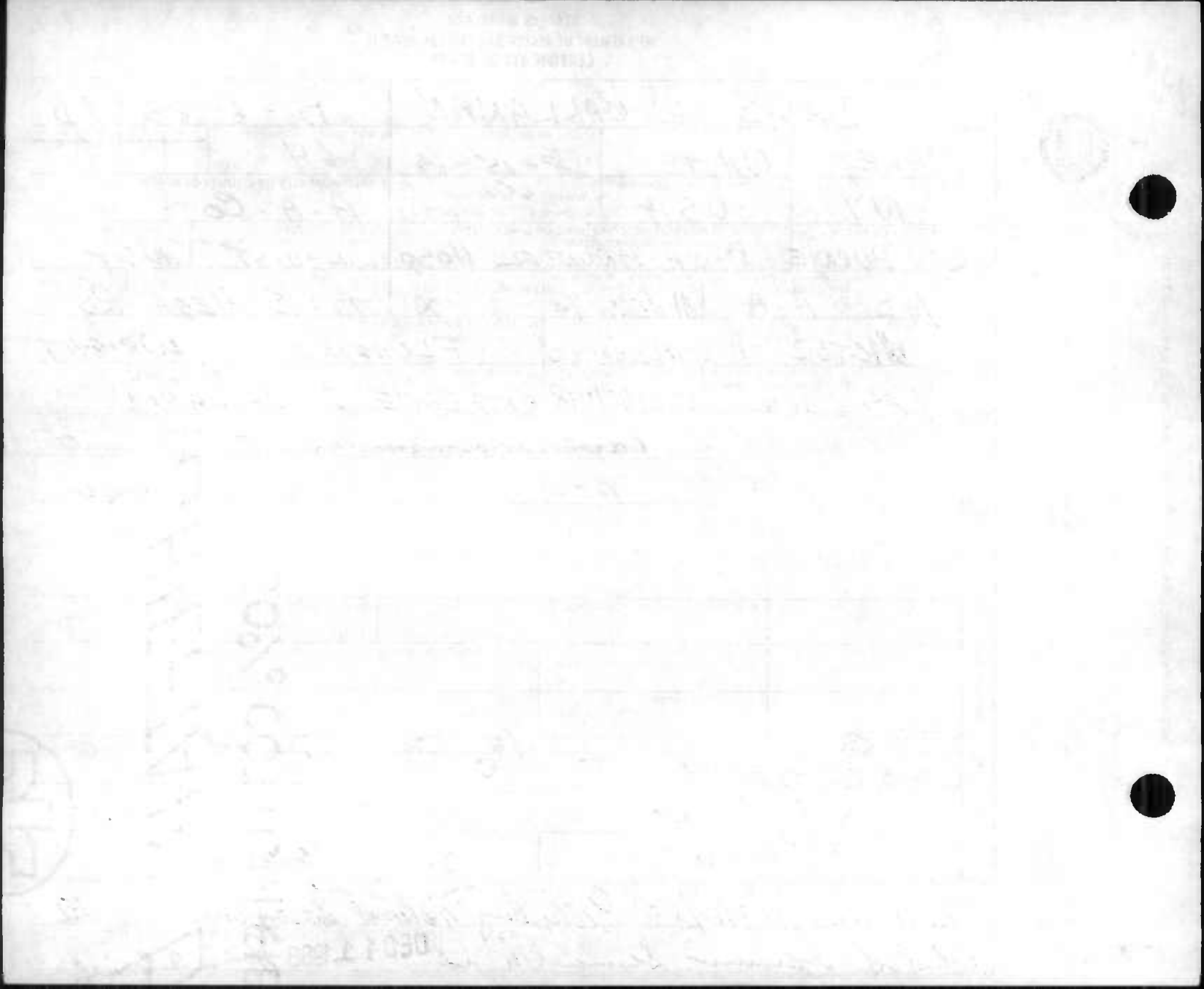
| | | | | | | | | | | | |
|--|--|---|--|---|---------------------------------------|---|--|--|--|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) DAVID W CALLANAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-6-83 | | | 2b. HOUR 7 p.m. | | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 8-15-19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A-A-Co MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LINGUIST | | 12b. KIND OF BUSINESS OR INDUSTRY NSA | | | |
| 13a. STATE MD | | | 13b. COUNTY A-A | | 13c. CITY OR TOWN MILLERSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 772 S. MESA RD. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST VICTOR J. CALLANAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE WRIGHT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WWW-1 050167098 | | 17. INFORMANT ADDRESS ABOVE KATHERINE I. CALLANAN | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASHN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. years. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/6 , 19 78 , to present , 19 83 , that (1) (we) last saw the deceased alive on 11/4 , 19 83 , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE L. F. Alvarez | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/7/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. F. Alvarez | | | | | | 22e. ADDRESS 3001 S. HANOVER ST. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE 12/17/83 | | | 23c. NAME OF CEMETERY OR CREMATORY Gettysburg National Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pa | | |
| 24. FUNERAL DIRECTOR Robert A. Bannan | | | | | | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE DEC 12 1983 John J. Carney | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3. RETURN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IMMEDIATELY WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

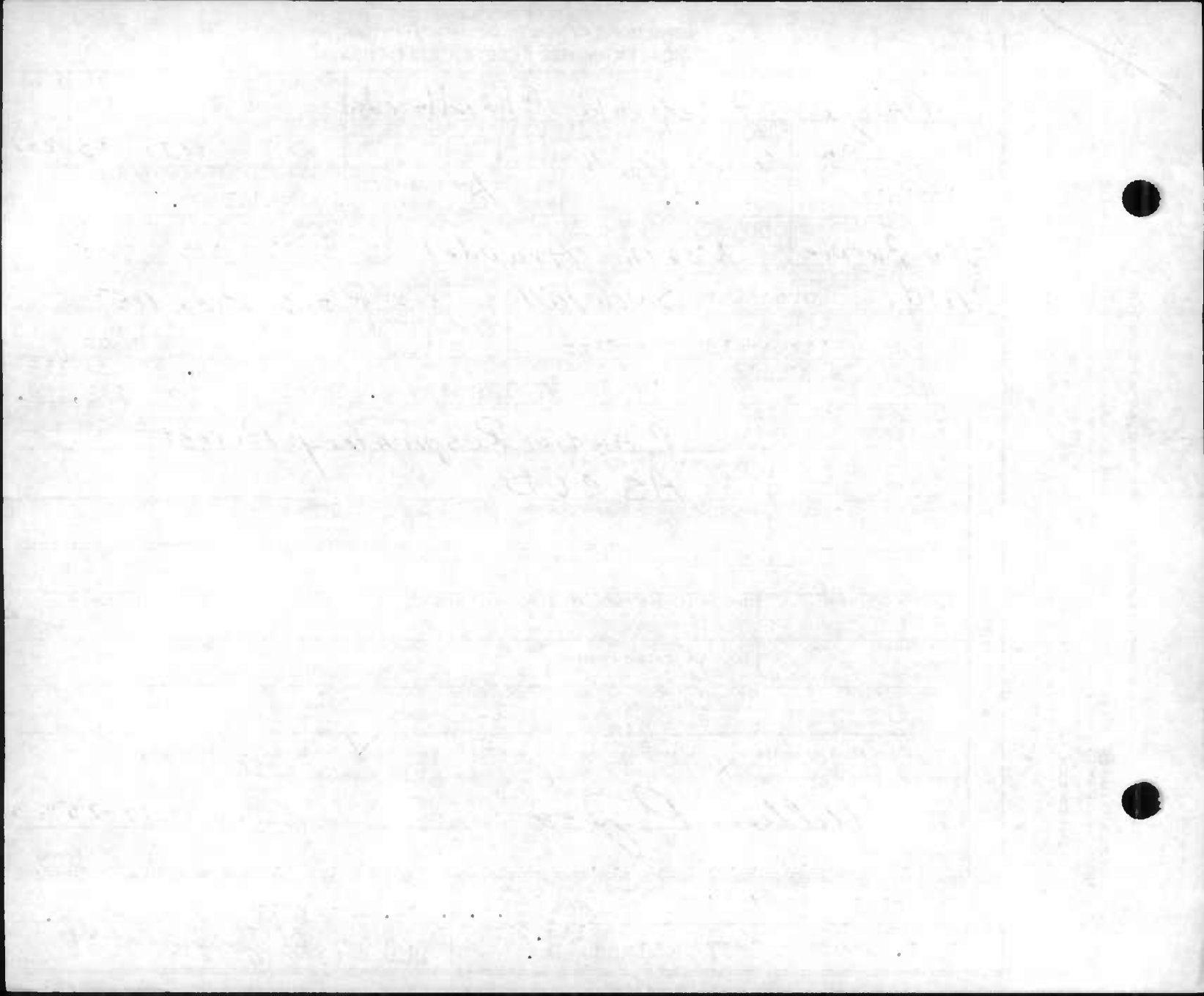
BP

DHMH - 17
(VIR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|---|---|--|---|--------------------------------------|--|----------|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | |
| CARSON Fitzgerald Chandler Jr. | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 2d. HOUR |
| Male | Can | 2 24 13 | 70 YRS. | | | 12 25 83 | 1237 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Virginia | U.S. | | | | A. Arundel Co. MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Glen Burnie | North Arundel | | Metallurgist | | Steel | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | |
| Md. | Worcester | Snow Hill | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | Rte 3 Box 115 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Carson Fitzgerald Chandler | | Edith Walsh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| no | | 179 09 9755 | | Dorothy B. Chandler Rt. #3 Box 115 Snow Hill, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: | | | | | | | |
| 4292 IMMEDIATE CAUSE (a) CARDIO Respiratory Arrest | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) AS CVD | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | |
| William P. Jones | | M.D. Deputy | | | | 12-25-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | |
| William P. Jones, M.D. | | 695 America Ct. Davidsonville 21035 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| burial | 12/28/83 | thatcoat U.M.C. Cem. | | Snow Hill | | Worcester, Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Gary L. Kaufman 5837 Bellanca Dr. | | DEC 27 1983 | | John J. Smith | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31551

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Peter W. Christensen | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 17 83 | | | 2b. HOUR 7:40 A. | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Jan 2 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Denmark | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Ann Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ann Arundel General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter-Self Employed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. Ann Arundel Riva | | 13b. COUNTY Ann Arundel | | 13c. CITY OR TOWN 3098 Tudor Hall Rd. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carl Christensen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Hansen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF SO, GIVE BRANCH) (IF YES, GIVE WAR OR DATES) None | | | | 16b. SOCIAL SECURITY NO. 579 03 9391 | | 17. INFORMANT ADDRESS Anna E. Christensen (Wife) Same as 13F. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 19 82 to Nov 15 19 83 , that (I) (we) last saw the deceased alive and above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE George C. Samaras | | | | | | DEGREE MD | | 22c. DATE SIGNED 12/17/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras | | | | | | 22e. ADDRESS 205 Ridgely Ave Annapolis | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/20/83 | | 23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery Wash.D.C. | | | 23d. LOCATION CITY TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi 11800 New Hampshire Ave.S.S. | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 20 1983 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | |

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: (Item 21) is marked as item 18 (b) (3) (iv) or other traumatic event, the medical examiner must be notified by phone.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 13 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1 DECEASED NAME FIRST MIDDLE LAST Samuel Edgar Clark | | | | 12-12-83 250 AM | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 8 27 97 | | 6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Annap. Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD | |
| 10 CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNA CONV. Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY Civil Service | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. MD 13b. COUNTY A.A. 13c. CITY OR TOWN Annapolis | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William George Clark | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Lowman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO 1WWL | | | |
| 17 INFORMANT John N. Wilson, Jr | | | | ADDRESS Same as #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pneumonia 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Friedlund Virus (c) Probable Pertussis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 78 to 12/12 19 83, that (I) [we] last saw the deceased alive on 12-7-19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Blane | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 12/16/83 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 14 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD | |
| 24 FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis, MD | | | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

100-211-2500 • Fax: 100-211-2501 • Email: info@hawaii.gov

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SUNNY NMN Coates | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 6 83 | | | 2b. HOUR MIN. 11 50 A.M. | |
| 3. SEX m | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 4 29 94 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 89 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD. | |
| 10. CITY OR TOWN OF DEATH Crownsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFIELD NURSING Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad Empl. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Henry Coates | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luvenia White | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216 10 2511 | |
| 17. INFORMANT Lucille Harris | | 17. ADDRESS 5 Admiral Dr. | | 17. ADDRESS Annapolis MD | | 17. ADDRESS 21401 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Metastatic cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE H. Pold | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-9-83 | | 23c. NAME OF CEMETERY OR CREMATORY Carpenters Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Severna Park A.A. MD | |
| 24. FUNERAL DIRECTOR NAME C.E. Hicks | | 24. ADDRESS ANNAPOILIS MD. | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |



[Faint, illegible handwritten text and markings covering the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| Item 19a&b Film 587 FOR 1. STATE 1-19-84 cn REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT WILMER COSTIN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 19, 1983 | | | | 2b. HOUR 2:13 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 62 | | 8. IF UNDER 24 HRS. 2:13 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. City | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY --- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2324 Sidney Avenue, 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Maurice D. Costin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Elizabeth Seymour | | | | 16. ADDRESS Same as #13 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 212-12-2794 | | 17. INFORMANT Donohty M. Costin | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 2384 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) polycythemia vera DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Recent lt pneumonectomy due to bronchogenic carcinoma | | | | | | | | | | | |
| 19a. DATE OF OPERATION 10-26-83 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bronchogenic Ca. | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 5 , 19 83 , to 11 19 , 19 83 , that (I) (we) last saw the deceased alive on 11 19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Mustafa C. Oz | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11 20 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUSTAFA C. OZ, M.D. | | | | 22e. ADDRESS 605 BALTIMORE-ANNAPOLIS BLVD.-SEVERNA PARK, MARYLAND 21146 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/23/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cem.-Crownsville | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, AA Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Homes | | | | 24b. ADDRESS Balto. Md., 21225 237 E. Patapsco Ave., | | 25a. DATE REC'D. BY REGISTRAR NOV 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | |

BP 371

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1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|-----------------------------------|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM | | FIRST WILLIAM | | MIDDLE CROWNER | | LAST CROWNER | | 2a. DATE OF DEATH MONTH DAY YEAR 12 28 83 | | 2b. HOUR 6:20 PM | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 12 25 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD | | | | | |
| 10. CITY OR TOWN OF DEATH CROWNSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FARIFIELD NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN GALESVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Benning Road 20765 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM CROWNER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE CROWNER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-09-0667 | | 17. INFORMANT ADDRESS HAROLD BADEN 1966 Forest Drive Annapolis, Md. 21401 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4100 DUE TO, OR AS A CONSEQUENCE OF: (b) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Cardiovascular diseases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 days | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Peripheral vascular disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY WRITTEN IN PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 19 80 to Dec 28 83 that (I) (we) last saw the deceased alive on Dec 28 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dr. Whitcomb, M.D. | | | | 22c. DATE SIGNED 12/30/83 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 1-3-1984 | | 23c. NAME OF CEMETERY OR CREMATORY EBENEZER A.M.E. CHURCH | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Galesville A.A. Maryland | | | |
| 24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORUATAM, P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE James J. Conley | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE D. CURLEY | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-23-83 | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 6-30-15 | | 2b. HOUR 10 ¹⁵ M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ARK. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 515 DEWEY DR. | | 9. BALTIMORE CITY OR COUNTY OF DEATH A-A-Co. | | MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | | | | 12b. KIND OF BUSINESS OR INDUSTRY GOUT. | | | |
| 13a. STATE MD. | | | | 13b. COUNTY A-A. | | 13c. CITY OR TOWN ANNAPOLIS | |
| 14. FATHER'S NAME FIRST MIDDLE LAST R. E. ROTH | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH SANDERS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS 1247 TAMARACK TR. RICHARD S. CURLEY-ARNOLD, MD. | |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): SEVERE COPO | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 79, to December 19 83, that (I) (we) lost the deceased alive on December 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Stuart E. Selonick | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick | | | | 22e. ADDRESS AAG Hospital Franklin St. Annapolis Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 12/27/83 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD. | |
| 24. FUNERAL DIRECTOR John S. Benanco | | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE John S. Benanco | | | | | | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ethel Margaret Davey</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>12-17-83</i> | | 2b. HOUR <i>240 P.M.</i> | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 3 00</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>83</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> | |
| 10. CITY OR TOWN OF DEATH <i>Annapolis, Md.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hosp</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>—</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 13a. STATE <i>Maryland</i> | | | | 13b. COUNTY <i>A. Arundel</i> | | 13c. CITY OR TOWN <i>Herald Harbor</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Robert Sharrett</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Elizabeth Howarth</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-16-6069</i> | | 17. INFORMANT <i>Jeanne E. Moore</i> | | ADDRESS <i>9 Kimberly Court Severna Park, Maryland</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Colon Carcinoma</i> <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>—</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Congestive Heart Failure</i> | | | | | | | |
| 19a. DATE OF OPERATION <i>12/13</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>12/13</i> , 19 <i>83</i> , to <i>12/17</i> , 19 <i>83</i> , that (1) (yes) last saw the deceased and on <i>12/17</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE <i>George P. Samaras</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>12/17/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>George P. Samaras</i> | | 22e. ADDRESS <i>205 Ridgely Ave Annapolis, MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>12-20-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Sunset Memorial Park</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cumberland Allegany MD</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Leasure-Stein Funeral Home, Inc.</i> <i>230 Baltimore Ave. Cumberland, MD 21502</i> | | | | 25. DATE REC'D. BY REGISTRAR <i>DEC 23 1983</i> | | | |
| | | | | 26. REGISTRAR'S SIGNATURE <i>John J. Calver</i> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Virginia D. Davis | | 2a. DATE OF DEATH MONTH DAY YEAR December 30, 1983 | | 2b. HOUR 1:15aM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR December 27, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 204 Shana Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY Retired |
| 13a. STATE Md. | | 13b. COUNTY AA | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 204 Shana Road, 21061 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Newton Sandridge | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-09-3186 | | 17. INFORMANT ADDRESS Howard Trainer, Nephew, same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 1840 DUE TO, OR AS A CONSEQUENCE OF (b) Vaginal Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION 1983 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED* (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 83 to Dec 19 83 , that (I) (we) lost saw the deceased alive on Nov 31 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Neil B. Rosenshein | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/31/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil B. Rosenshein | | 22e. ADDRESS The Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3 Jan. 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md | | 24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, Maryland | | | |
| 25a. DATE REC'D BY REGISTRAR JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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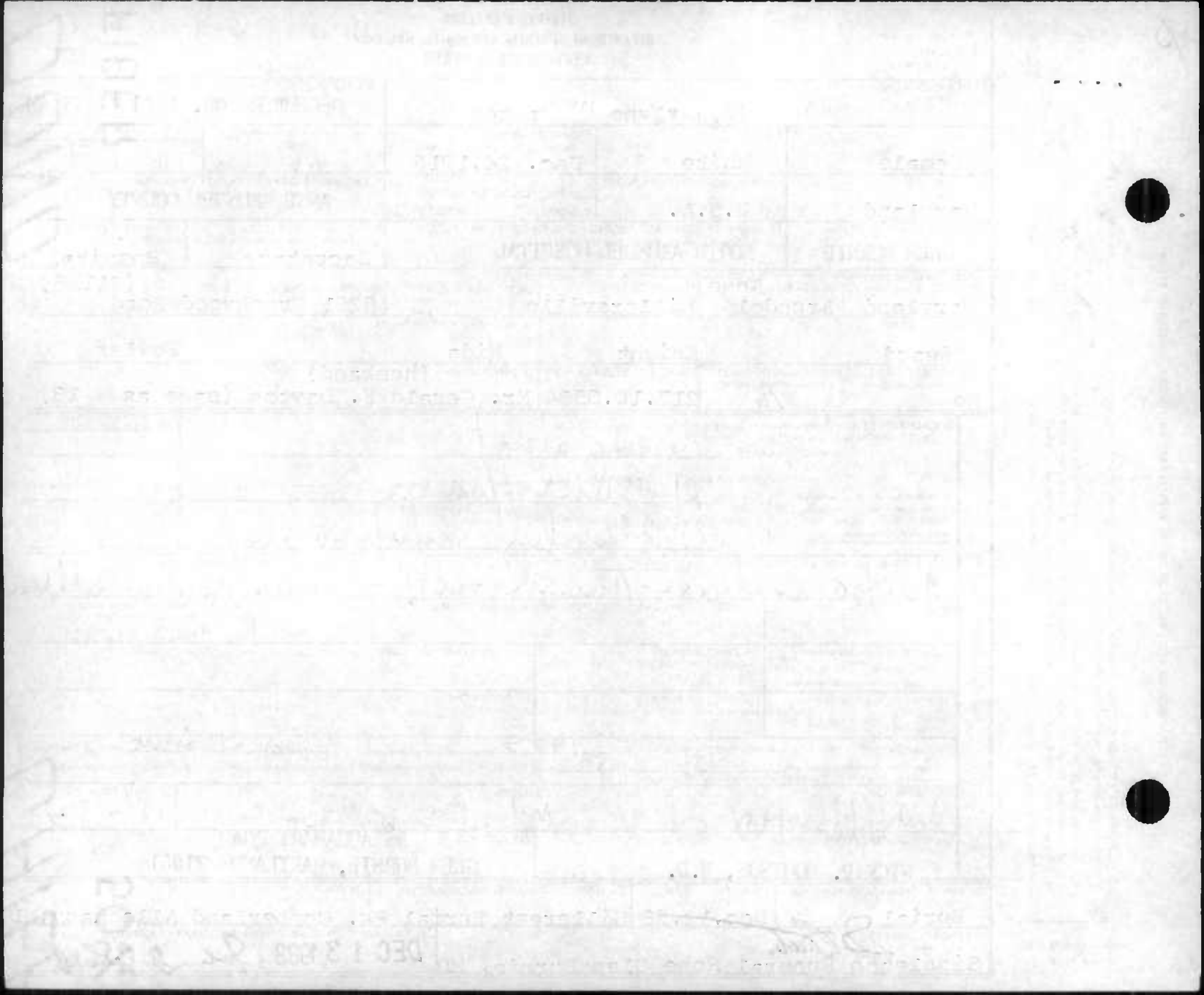
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Carton of
Vaseline

W. B. Brown
The First of June, 1914

MEDICAL CERTIFICATION

DHMH - 16 50M 4/83
(VRA 15, 4)



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| FOR 1. STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST John F. Demczuk | | MONTH DAY YEAR December 4, 1983 | |
| 3. SEX Male | | 2b. HOUR 2 PM | |
| 4. RACE White | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1924 | | YRS. MONTHS DAYS HOURS MIN. 59 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital Crane Repair Beth. Steel | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Baltimore Dundalk | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 113 Woodland Ave. 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ivan Demczuk | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alexandria Czaropinska | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES WW II | | 16b. SOCIAL SECURITY NO. 218-14-6977 | |
| 17. INFORMANT Kathleen M. Demczuk (same as line 13) | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30/68 to 12/4 19 83 , that (I) (we) last saw the deceased alive on 10/19/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Theodore C. Patterson M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Theodore C. Patterson, M.D. | | 22e. ADDRESS 3427 Dundalk Ave., Dundalk, Md. 21222 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 8, 83 | |
| 23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. of Mary Dundalk, Baltimore, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk, Inc. | | 25a. DATE REC'D. BY REGISTRAR DEC 7 1983 | |
| 25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i> | | | |

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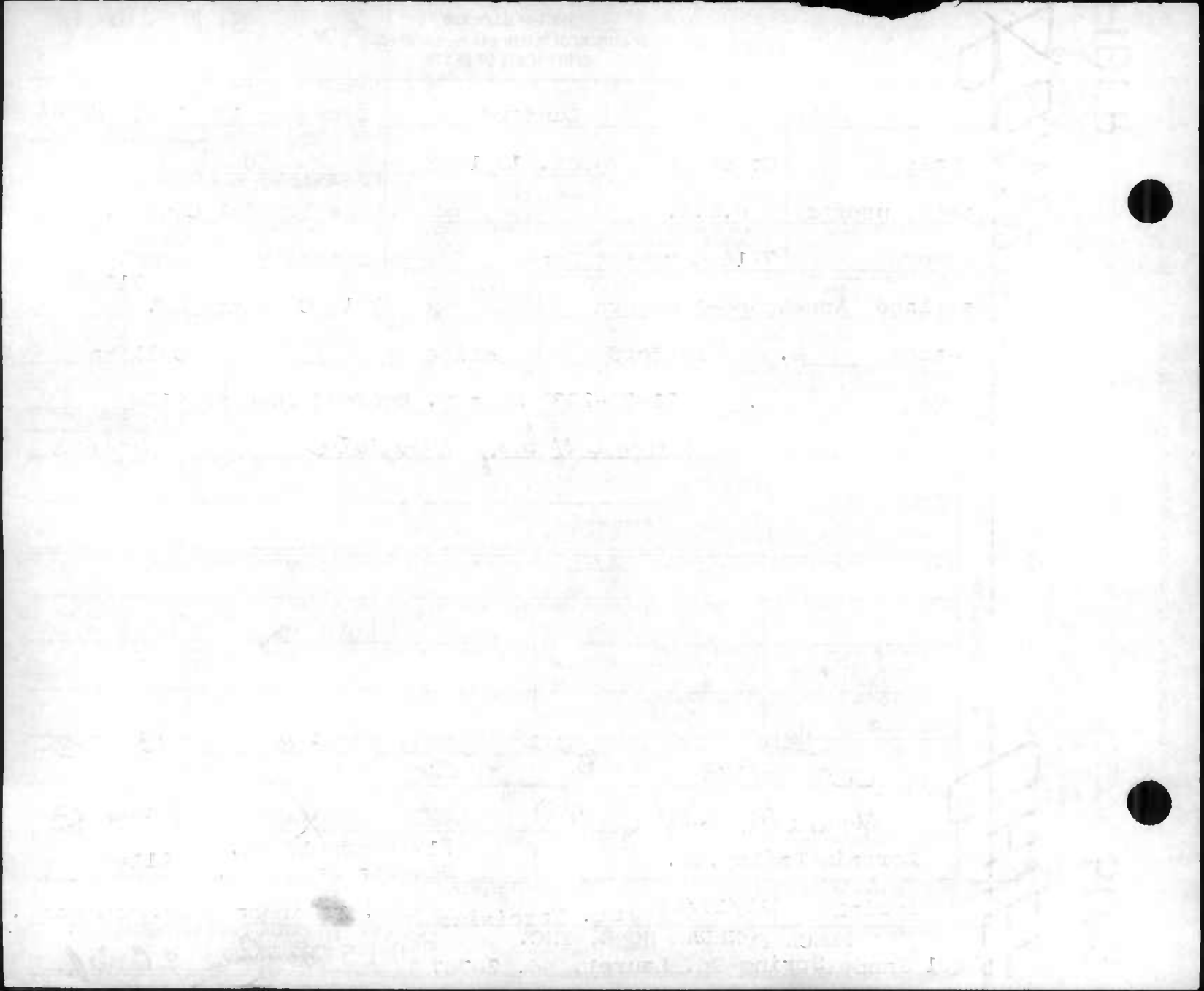
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) John F Dunford | | | 2a. DATE OF DEATH MONTH DAY YEAR December 13 1983 | | | 2b. HOUR 10:30 PM | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 19 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD. | | | |
| 10. CITY OR TOWN OF DEATH Severn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7916 Coventry Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security | | 12b. KIND OF BUSINESS OR INDUSTRY NSA | | |
| 13a. STATE Maryland | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Severn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James A. Dunford | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Cullina | | | 13e. STREET ADDRESS / ZIP CODE 7916 Coventry Rd. 21144 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 021-26-2335 | | 17. INFORMANT ADDRESS Anna M. Dunford Same as #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung - metastatic 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Nospice | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 517 Benfield Rd. Severna Park, Md. 21146 | | 22c. DATE SIGNED 12/14/83 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/12/83 to 12/13/83, that (I) (we) most saw the deceased alive on 12/13/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Lorraine M. Dailey MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lorrain Dailey, MD. | | 22e. ADDRESS 517 Benfield Rd. Severna Park, Md. 21146 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY St. Tarcisius Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Framingham Mid. Sex. Mass. | | | |
| 24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME, INC. ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 15 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31562

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANNA CLAIRE DUVALL | | | 2a. DATE OF DEATH MONTH 12 DAY 30 YEAR 83 | | | 2b. HOUR 12³⁰ PM | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH 8 DAY 15 YEAR 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7. UNDER 1 YEAR MONTHS 0 DAYS 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ADWEE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. GEN Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MD. | | 13b. COUNTY AA | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 1806 PLEASANT PLAINS RD. 21401 | |
| 14. FATHER'S NAME FIRST JOHN MIDDLE WESLEY LAST CARTER | | 15. MOTHER'S MAIDEN NAME FIRST EMMA MIDDLE L. LAST MUHLMEISTER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 114 805019 | | 17. INFORMANT WERNIS W. DUVALL #13 | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma 2028 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15 83 to 12/30 83 , that (I) (we) last saw the deceased alive on 12/30 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE E. W. COLE III | | | | DEGREE MD | | 22c. DATE SIGNED 12/30/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE III | | | | 22e. ADDRESS 51 FRANKLIN ST. ANNAPOLIS MD. 21401 | | | |

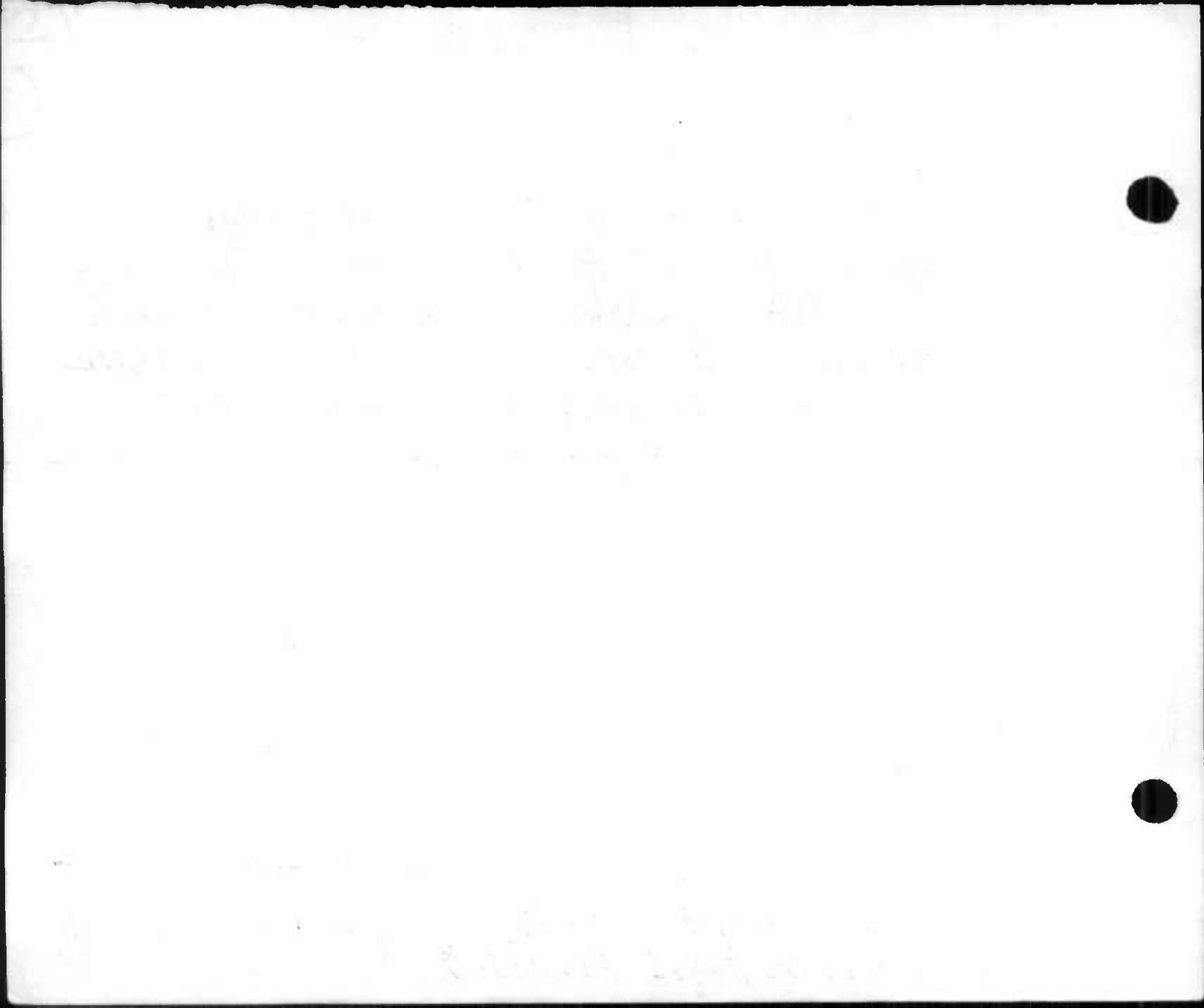
| | | | | | | | |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/2/84 | | 23c. NAME OF CEMETERY OR CREMATORY ST. MARYS | | 23d. LOCATION CITY OR TOWN ANNAPOLIS COUNTY AA STATE MD | |
| 24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL ADDRESS ANNAPOLIS | | | | 25a. DATE RECD. BY REG. CLERK JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE John D. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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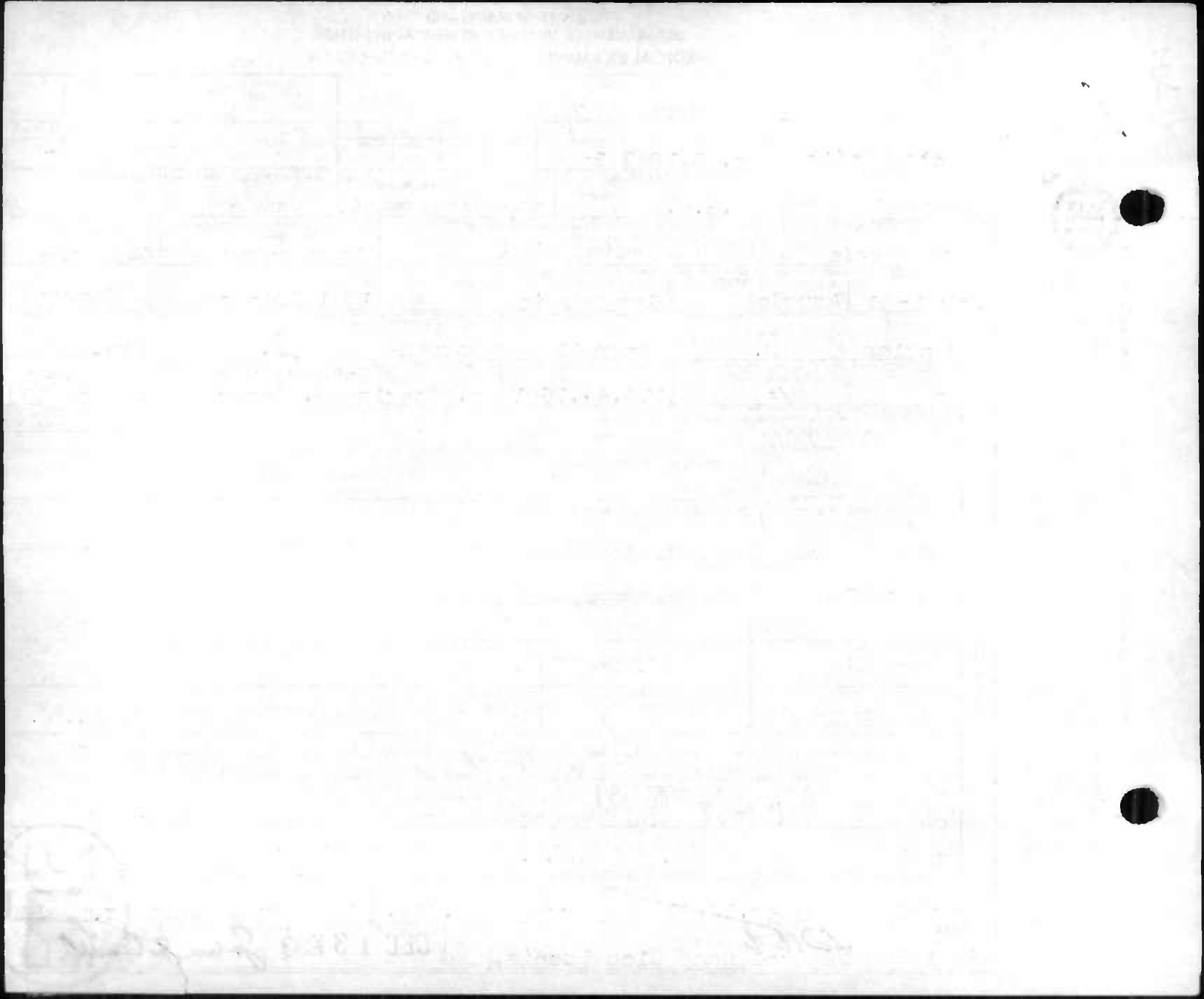


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. |
|--|------------------|--|---|---|------------------|---|--|---|--|----------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JUNE Esther EASTON | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-9-83 19 | | 2b. HOUR M | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 3, 1947 | 6. AGE (IN YEARS) LAST BIRTHDAY 36 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-9-83 19 | | 7d. HOUR M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY Own home | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1581 Dulaney Lane (21061) | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Carroll | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Bragg | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT (father) Mr. Charles W. Carroll | | ADDRESS 7869 Leymar Road (21061) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-?-83 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) caught in housefire | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1581 Dulaney Avenue Anne Arundel Co., Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | TITLE (SPECIFY) M.D. Assistant | | MEDICAL EXAMINER | | | | DATE 12-9-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 12, 83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Anne Arundel MD | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Singleton</i> | | ADDRESS Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | EST | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLARD HENRY EBBERTS SR | | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 16, 1983 | | 2b. HOUR 1135 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 10, 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 49 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Eng. | | 12b. KIND OF BUSINESS OR INDUSTRY A.A.Dept. of Ec | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | | | 13b. COUNTY Anne Arunde | | 13c. CITY OR TOWN Severn | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willard J. Odenbeck | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Helmick | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO. 4300 | | 17. INFORMANT ADDRESS Laura M. Ebberts same as 13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SUB ARACHNOID HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4300</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>4300</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERED T. KAHN M.D. | | 22e. ADDRESS 7575 RITCHIE HIGHWAY, S.E. GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 20 Dec. 83 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD. | |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley Glen Burnie MD. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

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200-1-10M
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) TIMMY LEE EHRHART-COHN | | | | 2a. DATE OF DEATH MONTH 12 DAY 22 YEAR 83 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 2 DAY 21 YEAR 42 | | 6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH Millersville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 232 Michele Circle | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Human Services | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Millersville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Elden MIDDLE E. LAST Ehrhart | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE E. LAST Butts | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 172-34-3124 | | 17. INFORMANT ADDRESS Michael Lee Cohn (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread pulmonary metastases DUE TO, OR AS A CONSEQUENCE OF: (b) Adenocarcinoma of the Breast. DUE TO, OR AS A CONSEQUENCE OF: (c) _____ 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1 , 19 83 , to Dec 22 , 19 83 , that (I) (we) last saw the deceased alive on Dec 21 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did) not view the body after death. | | | | | | | |
| 27a. SIGNATURE George Taler, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Dec 23, 1983 | |
| 27b. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE TALER, M.D. | | 22a. ADDRESS 600 LIGHT ST. Balto. Md. 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12-23-83 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., md. | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce F.H. 4001 Ritchie Hwy. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 23 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Lankish | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 there was any injury, or other traumatic event, the medical examiner must file a report of death.

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DHMH-16 30M 2/80
(VRA 15, 4)1. FOR
STATE
REGISTRARItem #2b Film #G588
2/6/84 jpSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOANNETTE D. EILERMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR DEC 16, 1983 | | 2b. HOUR 11:00 AM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 7 19 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Conv. Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Harford Bel Air | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 103 S. Reed Street 21014 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur Ledford | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218 26 0707 | | 17. INFORMANT ADDRESS Richard Eilerman same as 13 e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) M.S. - Complications 3400 DUE TO, OR AS A CONSEQUENCE OF (b) Multiple CVA, UTI's DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 83 , to 12/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE H. T. ... | | DEGREE M.D. | | 22c. DATE SIGNED DEC 19 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem Pk | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | 23e. DATE RECEIVED BY REGISTRAR 23f. REGISTRAR'S SIGNATURE DEC 19 1983 Joan J. Connel | | | |
| 24. FUNERAL DIRECTOR NAME Balto. Md. 21225 | | 24b. ADDRESS George J. Gonce 4001 Ritchie Hwy | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 33 31567 | | | | | |
|---|--|---|--|---|---|---|--|--|---|--|--|-------------------------------------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Daniel McElroy Entler, Jr. | | | | | 2a. DATE OF DEATH MONTH 12 DAY 11 YEAR 83 | | | | | 2b. HOUR 7:15 PM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 01 DAY 13 YEAR 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oregon | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | | | | | |
| 13a. STATE MD | | | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 110 Americana Drive 21403 | | | | |
| 14. FATHER'S NAME FIRST Daniel MIDDLE McElroy LAST Entler, Sr | | | | | 15. MOTHER'S MAIDEN NAME FIRST Edna MIDDLE Virginia LAST Apsley | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES) 11W11 | | 17. INFORMANT Dorothy C. Entler | | | ADDRESS same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Colon Cancer 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (we) hospital attended the deceased from 62 19 62 to 12/11 19 83 , that (I) (we) lost saw the deceased alive on 12/11 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE R. I. Hochman, MD | | | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/12/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. I. Hochman, MD | | | | | | | | 22e. ADDRESS 16 Mercers Ave, Annapolis, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK BY) Burial | | | | 23b. DATE Dec 16, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington VA | | | | | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD | | | | | | | | ADDRESS DEC 14 1983 | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN PAUL FARACI | | | 2a. DATE OF DEATH MONTH DAY YEAR December 1 83 | | 2b. HOUR 12⁴⁵ AM |
| 3. SEX MALE | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 18 41 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher | | 12b. KIND OF BUSINESS OR INDUSTRY Produce |
| 13a. STATE MARYLAND | | | 13b. COUNTY ANNE ARUNDEL | 13c. CITY OR TOWN GLEN BURNIE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Paul J. Faraci | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances D. Angell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-40-9278 | | 17. INFORMANT Mother ADDRESS Glen Burnie Maryland | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **ACUTE LEUKEMIA****2080**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1977 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on 12/1/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Harry M. [Signature] | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 12/1/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | |
|--|--------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Dec. 5, 83 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. [Signature] |
| 24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home, Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 6 1983 [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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| | | | | | |
|---|--|--|---|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| James Joseph Fenton | | 12 14 83 | | 11 P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS (LAST BIRTHDAY)) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Male | Caucasian | April 12, 1939 | 44 | Anne Arundel County MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| New York | USA | | C. P. A. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Annapolis | Anne Arundel General Hospital | U.S. Government | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Anne Arundel | Davidsonville | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1112 Rutlandview Dr. 21035 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 17. INFORMANT | | | |
| Timothy Fenton | M Anne Galvin | 1112 Rutlandview Drive 21035 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | Mrs. Barbara M. Fenton Davidsonville, MD | | | |
| YES | 1959-1961 | 074-30-6198 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> | | | | | |
| 4100 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| (b) <u>Probable Myocardial Infarction</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 1) Hypertension 2) Hyperlipidemia | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/26, 1978, to 12/14, 1978, that (I) (we) last saw the deceased alive on 12/14, 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Joseph N. Friend | MD | | | 12/16/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| Joseph N. Friend | 205 Rutledge Ave. Annapolis, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 12-19-83 | Gate of Heaven Cemetery | Valhalla, West Chester, NY | | |
| 24. FUNERAL DIRECTOR NAME | 25. DATE REC'D. BY REGISTRAR | 26. REGISTRAR'S SIGNATURE | | | |
| Beall Funeral Home | DEC 21 1983 | John J. Conner | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove certificates Pages 3 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dolores C. Flake | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-9-83 | | 2b. HOUR 9:45A |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7 19 25 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 58 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 115 Doris Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | 12b. KIND OF BUSINESS OR INDUSTRY Soc. Security | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST George L. O'Connor | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Wroten | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 219-16-4692 | 17. INFORMANT ADDRESS Cynthia Turnbull 428 Philbate Terrace Virginia Bch, Va 23452 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 Small Cell Lung Cancer IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 19 85 to 12 19 83 , that (I) (we) last saw the deceased alive on 12 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Philip Kenits | | DEGREE | | 22c. DATE SIGNED 12/9/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip Kenits | | 22e. ADDRESS 615 Hammonds Lane | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/12/83 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto A.A. Md |
| 24. FUNERAL DIRECTOR NAME George J. Gonce | | | ADDRESS 4001 Ritchie Hgwy Balto, Md | | 25a. DATE REC'D. BY REGISTRAR DEC 13 1983 |
| | | | | | 25b. REGISTRAR'S SIGNATURE John J. Canfield |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

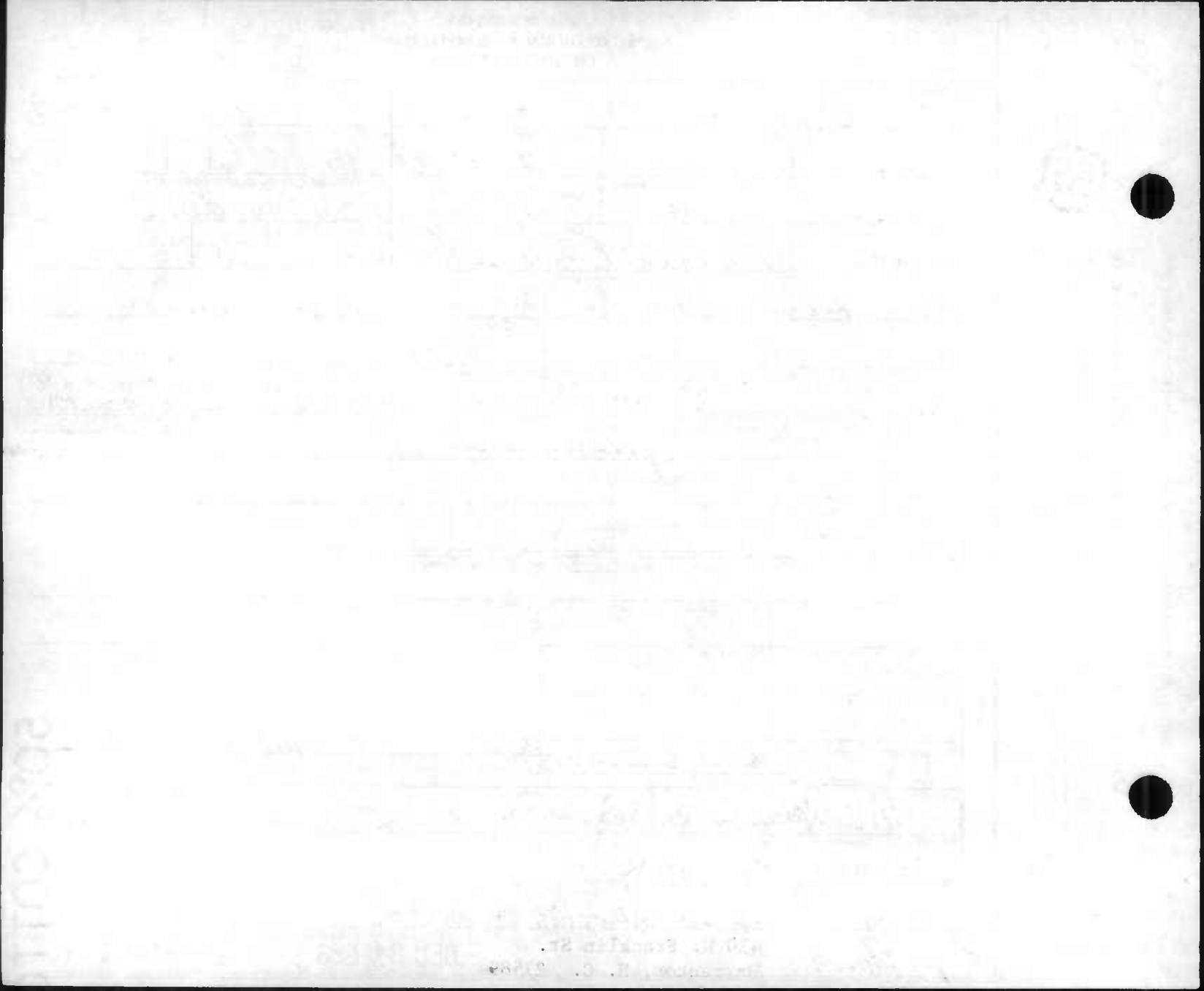
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal certificate must be notified.

BP

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Clara B Fogg | | 2a. DATE OF DEATH MONTH DAY YEAR 12 18 83 | | 2b. HOUR 9 40 A M | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 2 17 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE Md. | | 13b. COUNTY Anne Arundel Co. | |
| 13c. CITY OR TOWN Churchton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5351 Deale Churchton Rd. 20733 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Dunston | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Ingram | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-24-7673 | | 17. INFORMANT Mrs. Edna D. Offer | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>early December 1983</u> , 19 <u>1983</u> , to <u>12/18/83</u> , 19 <u>1983</u> , that (1) (last saw the deceased alive on <u>12/18/83</u>) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) (we did not) view the body after death. | | | | | |
| 22b. SIGNATURE Dr. SELOVICK | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/18/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STUART SELOVICK | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-22-83 | | 23c. NAME OF CEMETERY OR CREMATORY Mitchell Church Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Franklin Co. N.C. | | 24. FUNERAL DIRECTOR NAME J. F. Harris | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 28 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|------------------------|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FORRESTER, Robert | | 2a DATE OF DEATH MONTH DAY YEAR 12-23-83 | | 2b HOUR 54 M | |
| 3 SEX M | 4 RACE NEgro | 5 DATE OF BIRTH MONTH DAY YEAR 3 4 80 | | 6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? U.S. | | 9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10 CITY OR TOWN OF DEATH MILLERSVILLE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KNOLLWOOD MANOR Nsg. Hm. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD | | 13b COUNTY ANNE ARUNDEL | | 13c CITY OR TOWN ANnapolis | |
| 14 FATHER'S NAME FIRST MIDDLE LAST DANIEL FORRESTER | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA MILES | | 13d STREET ADDRESS 27 College Cr. Terrace | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT ADDRESS FLORINE BONNER 4046 Abingdon, Md. 21009 | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

4029

DUE TO, OR AS A CONSEQUENCE OF

(b)

171 A.C.V.D

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**minutes****Years**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/2/78 , 19 83 , to 12/23 , 19 83 , that (I) (we) last saw the deceased alive on 12/23 , 19 83 , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Faye W. Allen | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 12/23/83 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) FAYE W. ALLEN | | | | 22e ADDRESS 1323 Magnolia Ave Annapolis | | | |

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|---|--|-------------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 12-27-1983 | | 23c NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK | | 23d LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | |
| 24 FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a DATE REC'D. BY REGISTRAR JAN 4 1984 | | 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/B3
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| | | | | | | | | | | |
|--|--|---|---|---|---|--|---|--|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) MADELEINE Sylvia GALLION | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 14, 1983 | | | 2b. HOUR 245 AM | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 1, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (Ret.) (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Hgt. Linthicum | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 206 Maple Road (21090) | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frances William Gallion | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT (friend) ADDRESS Mrs. Joan Lee Hodgkins Mt. Airy Md. 6627 Runkles Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colon Cancer</u> Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 months 6 months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Anemia</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-18</u> , 19 <u>83</u> , to <u>12-14</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12-14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Long S. Hsu</u> | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12-14-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D. | | | 22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Dec. 17, 83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. MD | | | |
| 24. FUNERAL DIRECTOR NAME <u>Dean P. Thornton</u> | | | ADDRESS Singleton Funeral Home Glen Burnie, MD | | | 25a. DATE REC'D. BY REGISTRAR DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connelley</u> | | |

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29 of 201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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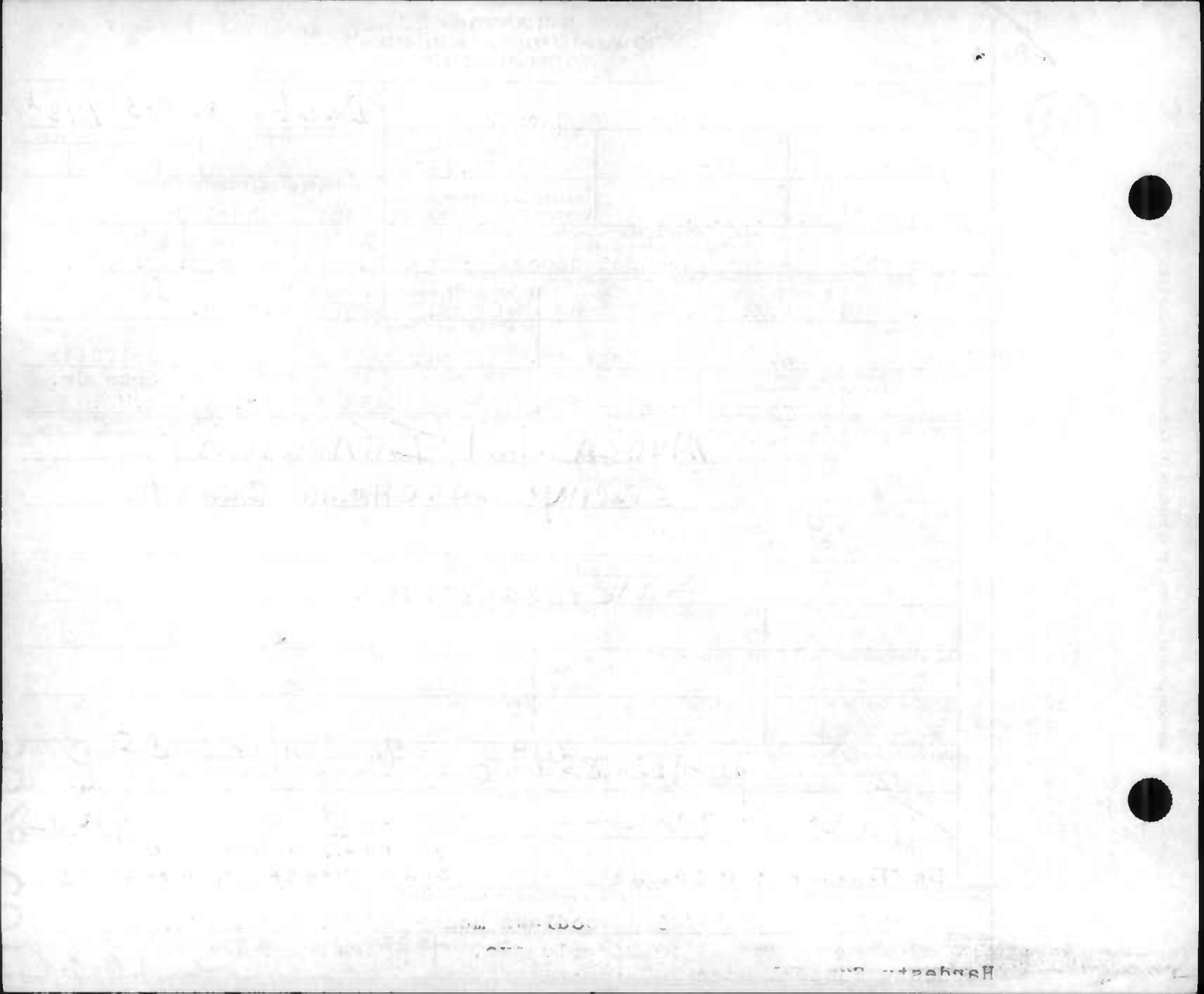
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|--|--|---|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Peggy Gray Garner | | | 2a. DATE OF DEATH MONTH DAY YEAR December 20, 1983 | | 2b. HOUR 1:13 A.M. | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR June 24, 1925 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Forrestville, Md. | | 8. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) anne Arundel General Hosp. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Education Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY P.G.Co. | | 13a. STREET ADDRESS 307 Berts Dr. 20711 | | |
| 13b. STATE Md. | | 13c. COUNTY A.A. Co. | | 13d. CITY OR TOWN Lothian | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ralph A. Gray Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Griffith | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | |
| 16b. SOCIAL SECURITY NO. 579-32-8113 | | 17. INFORMANT Wallace J. Garner Sr. | | ADDRESS 307 Berts Dr. Lothian, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4912 DUE TO, OR AS A CONSEQUENCE OF: (b) EMBOLISM & CHRONIC BRONCHITIS DUE TO, OR AS A CONSEQUENCE OF: (c) ARTERIOSCLEROSIS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (a) (this hospital) attended the deceased from saw the deceased alive on 12/18/83, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DR. Terence A. McGuire | | |
| 22c. DATE SIGNED 12/22/83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Terence A. McGuire | | 22e. ADDRESS 311 Addison Road South Seat Pleasant, Md. 20743 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/23/83 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn memorial | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Pk. Easton, Md. | | 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1983 | | |
| 25b. REGISTRAR'S SIGNATURE John J. Givens | | 25c. ADDRESS 12 Ridgely Ave. Ann. Md. 21401 | | 25d. DATE REC'D. BY REGISTRAR DEC 29 1983 | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH M. GERICH | | | | 2b. HOUR 12 05 83 6 ⁰⁰ P M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAR 9 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SISAK AUSTRIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN SEVANA PARK | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE MERIDIAN NURSING CTR. 21446 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ANDREW MAUROVIC | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES JUZNIC | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 181482684 | | 17. INFORMANT ADDRESS WALTER R. GERICH 762 OLD ANNAPOLIS MD 21401 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5850 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Anemia, Diabetes. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 10/22 19 82, to Dec 5 19 83, that (ii) (we) last saw the deceased alive on 12-5 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Thomas Walsh MD | | | | DEGREE MD | | 22c. DATE SIGNED 12/5/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS WALSH M.D. | | | | 22e. ADDRESS 269 Peninsula Farm Rd. ARNOLD MD. 21012 | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 12/9/83 | | 23c. NAME OF CEMETERY OR CREMATORY ALLEN CEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALLISON PARK PA. | |
| 24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL | | | | ADDRESS 21401 ANNAPOLIS MD | | 25a. DATE REC'D. BY REGISTRAR DEC 8 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Gough | | | |

-REG-16-



PROSPECTIVE INVESTMENT
STOCKS



BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|--|--|--------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 7b. HOUR | |
| Lemira D.J. | | | | | | Glendinning | | 12 22 83 | | 12 | | 22 | | 83 | | 0030 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| 7 | W | 7 31 20 | | 63 YRS. | | | | | | 12 22 83 | | 12 | | 22 | | 83 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Washington, DC | | USA | | MARRIED | | NEVER MARRIED | | Anne Arundel | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Annapolis | | Anne Arundel General Hospital | | Homemaker | | Home | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md | | AA | | Annapolis | | YES | | 221 King George St | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Arnold W. Jacobsen | | Lemira Cander | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | | | James I. Glendinning | | Same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | | | |
| 4100 | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| Myocardial infarct | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | | | | | |
| NOT WHILE AT WORK | | (AT HOME, STREET, FACTORY, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy | | Inspection | | Inquiry | | and in my opinion death resulted from: | | | | | | | | | | | |
| Natural causes | | Accident | | Suicide | | Homicide | | Undetermined manner | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | | | | | | | | | |
| James E. Wheeler | | M.D. Dep | | | | 14-22-83 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| JAMES E. WHEELER | | 910 Primrose | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Cremation | | Dec 23, 1983 | | Cedar Hill | | Suitland | | | | | | | | | | | |
| 24. | | | | | | | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|-------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STELLA E GRAY | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 17 83 | | 2b. HOUR 2P M | |
| 3. SEX F | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 11 21 28 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 54 55 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 209 Hammonds Ferry Rd. | | | 12. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. STATE MD. | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Linthicum | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Reddish | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST STELLA Burke | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-32-3881 | | 17. INFORMANT NAME AND ADDRESS John E. Gray, Home Record, Linthicum, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 3400 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Muscle weakness Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 3 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Sclerosis several years | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/5 19 83 , to 12/5 19 83 , that (1) (we) lost saw the deceased alive on 12/5 19 83 , and that (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Colvin C Carter MD | | DEGREE MD | | 22c. DATE SIGNED 12/18/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Colvin C-Carter | | 22e. ADDRESS 4700 Pennington Ave | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 12-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY Whitcomb Meth. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS Norman F. Dennis, Snow Hill, Md. | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 7 8

FOR
1- STATE REGISTRAR *Zip 21012*

REG. NO.

| | | | | | | | |
|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Clara Alma Green</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>12 26 83</i> | | | 2b. HOUR <i>9:15 AM</i> | |
| 3. SEX <i>F</i> | 4. RACE <i>B</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>10 16 19</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Annapolis</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Genne Arundel Gen.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>md</i> | | 13b. COUNTY <i>A.A.</i> | 13c. CITY OR TOWN <i>Arnold</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <i>530 Old Jones Station Rd</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Henry COATES</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LAVENIA White</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>215-32-0255</i> | | 17. INFORMANT ADDRESS <i>STERLING GREEN 530 Old Jones Station Rd</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>upper gastrointestinal hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>hemorrhagic gastritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1519</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>7 mo.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>1° esophageal proctotomy 2° adenocarcinoma of stomach</i> | | | | | | | |
| 19a. DATE OF OPERATION <i>May, 1983</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>gastric carcinoma</i> | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>2510 Riva Annapolis</i> | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>12/25/83</i> , 19____, to <i>12/26/83</i> , 19____, that (1) <input checked="" type="checkbox"/> saw the deceased alive on <i>12/26/83</i> , 19____, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above (or) (I did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Wm A Cassidy</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>12/26/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm A Cassidy</i> | | 22e. ADDRESS <i>2510 Riva Annapolis</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>12-29-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>CARPENTER HILL</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>A.A. md</i> | |
| 24. FUNERAL DIRECTOR NAME <i>C.E. Hicks</i> | | ADDRESS <i>1922 Forest Drive</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 4 1984</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELLA MAY GRIMES | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 23 1983 | | | 2b. HOUR 6:15 A M | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept 23, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR NAME OF WORKING LIFE) homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY own home | | | |
| 13a. STATE MD | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 24 Chester Circle 21061 | | |
| 14. FATHER'S NAME Joseph F. Smith | | | | 15. MOTHER'S MAIDEN NAME Mamie M. Hines | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) xxxxxxx 213/74/7988 | | 17. INFORMANT ADDRESS Dolores E. Winter (daughter) same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary vascular collapse due to 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) to Coronary artery thrombosis due (c) to Arteriosclerotic heart disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 10 1983 to Dec 23 1983 , that (I) (we) last saw the deceased alive on Dec 10 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Anastacio E. Subong Jr. | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12/23/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anastacio E. Subong Jr. M.D. | | | 22e. ADDRESS 206 Crain Hwy S.W. Glen Burnie Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 27 Dec. 83 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Pk | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, MD | | | |
| 24. FUNERAL DIRECTOR NAME Singleton | | | ADDRESS Funeral Home Glen Burnie Md. | | | 25a. DATE REC'D. BY REGISTRAR DEC 28 1983 | | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | |

BP

1. The first part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive hand, and the addresses are written in a more formal, printed style. The list is headed by the word "List" in a large, bold font.

2. The second part of the document is a table of numbers. The numbers are arranged in a grid, with rows and columns. The numbers are written in a cursive hand, and the grid is headed by the word "Table" in a large, bold font.

3. The third part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive hand, and the addresses are written in a more formal, printed style. The list is headed by the word "List" in a large, bold font.

4. The fourth part of the document is a table of numbers. The numbers are arranged in a grid, with rows and columns. The numbers are written in a cursive hand, and the grid is headed by the word "Table" in a large, bold font.

5. The fifth part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive hand, and the addresses are written in a more formal, printed style. The list is headed by the word "List" in a large, bold font.

6. The sixth part of the document is a table of numbers. The numbers are arranged in a grid, with rows and columns. The numbers are written in a cursive hand, and the grid is headed by the word "Table" in a large, bold font.

7. The seventh part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive hand, and the addresses are written in a more formal, printed style. The list is headed by the word "List" in a large, bold font.

8. The eighth part of the document is a table of numbers. The numbers are arranged in a grid, with rows and columns. The numbers are written in a cursive hand, and the grid is headed by the word "Table" in a large, bold font.

9. The ninth part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive hand, and the addresses are written in a more formal, printed style. The list is headed by the word "List" in a large, bold font.

10. The tenth part of the document is a table of numbers. The numbers are arranged in a grid, with rows and columns. The numbers are written in a cursive hand, and the grid is headed by the word "Table" in a large, bold font.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 8 0
EST

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|-------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Ellen LAST HAAG | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 16, 1983 | | 2b. HOUR MIN. 511 PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 27, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 58 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY at home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Chester MIDDLE A. LAST Young | | 15. MOTHER'S MAIDEN NAME FIRST Janet MIDDLE Lennox LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Earl V. Haag same as 13 E | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Undifferentiated carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 weeks</u> |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Adult onset Diabetes Mellitus

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-29</u> , 19 <u>83</u> , to <u>12-16</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Long S. Hsu</u> | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D. | | 22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MD 21061 | | | | | |

| | | | | | | | |
|---|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-21-83 | | 23c. NAME OF CEMETERY OR CREMATORY Hillside Mem. Prk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Akron Summit Co. Ohio | |
| 24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home | | | | ADDRESS 3204 Mountain Rd. | | 25. DATE REC'D. BY REGISTRAR DEC 20 1983 | |
| | | | | | | REGISTRAR'S SIGNATURE <u>John J. Gough</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>ELEANOR D. HALL.</u> | | | | | 2a. DATE OF DEATH MONTH <u>12</u> DAY <u>29</u> YEAR <u>83</u> <u>12:04</u> M. | | | | |
| 3. SEX <u>FEMALE</u> | | 4. RACE <u>WHITE</u> | | 5. DATE OF BIRTH MONTH <u>3</u> DAY <u>2</u> YEAR <u>92</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>91</u> YRS. | | 7. IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN. <u> </u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH <u>Annapolis</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel Gen. Hosp.</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>AA</u> | | 13c. CITY OR TOWN <u>Annapolis</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>H.</u> LAST <u>Hall III</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Eleanor</u> MIDDLE <u>Maria</u> LAST <u>Estep</u> | | 16. STREET ADDRESS / ZIP CODE <u>1015 NORMAN DR. Apt 77</u> <u>Annapolis MD 21403</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <u>217-36-4545</u> | | 17. INFORMANT <u>William Hall - Lothian</u> | | ADDRESS <u>5311 Old Solomons Island Rd</u> <u>MD 20711</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-Vascular Dx</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> Approximate interval between onset and death <u> </u> years. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u> </u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR <u> </u> A.M. MONTH <u> </u> DAY <u> </u> YEAR <u> </u> P.M. <u> </u> 19 <u> </u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET <u> </u> CITY OR TOWN <u> </u> COUNTY <u> </u> STATE <u> </u> | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Jan</u> 19 <u>83</u> , to <u>Dec 29</u> 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u> </u> 19 <u> </u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | |
| 22b. SIGNATURE <u>Barry R. Nathanson</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>12/29/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY R. NATHANSON</u> | | | | 22e. ADDRESS <u>51 FRANKLIN ST. ANNAP. MD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>Jan 1, 1984</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. James</u> | | 23d. LOCATION CITY OR TOWN <u>Lothian</u> COUNTY <u>AA</u> STATE <u>MD</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Taylor Funeral Chapel-Annapolis MD</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 4 1984</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Givich</u> | | | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 8 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) IVA Larena HANSEN | | | 2a. DATE OF DEATH MONTH 12 DAY 11 YEAR 83 | | | 2b. HOUR 3A M. | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH 9 DAY 28 YEAR 91 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH Edgewater | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Conv. Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beauty salon | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY A.A. Co | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Albert MIDDLE Wells LAST Wells | | 15. MOTHER'S MAIDEN NAME FIRST Clara MIDDLE unknown LAST unknown | | 13e. STREET ADDRESS 130 Hearn Rd. Apt. 803 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 547-26-0160 | | 17. INFORMANT Richard Taylor ADDRESS Bowie, Md. | | | |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **ASCVD**
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>John J. Connel</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/15/83 | | 23c. NAME OF CEMETERY OR CREMATORY Cypress Lawn Cem. Assoc. Colma | | 23d. LOCATION CITY OR TOWN COUNTY STATE Calif | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Ann. Md. | | ADDRESS 12 Ridgely Ave. | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is checked, any injury, or other traumatic event, the medical certificate must be verified at page 4.

8-11-12

11-1

CVD

Item 13e per ph.
12/29/83 K.G.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL HEIFMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 - 13 - 83 | | 2b. HOUR 10 15 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 - 01 - 05 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | |
| 10. CITY OR TOWN OF DEATH Annapolis, Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 1221 Dietrich Way | | |
| 13a. STATE Glenwood House ACO | | 13b. CITY OR TOWN ANAPOLIS | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Morris Helfman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Rose Katz | | 17. INFORMANT ADDRESS 1221 Dietrich Way | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 103-12-1484 | | 17. INFORMANT ADDRESS Mr. Henry Warner Annapolis, Md. 21401 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia 2089 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/11, 1983 to 12/13, 1983 , that (I) (we) last saw the deceased alive on 12/13, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE R. I. Hochman, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/13/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OFFICIAL) R. I. Hochman, M.D. | | | | 22e. ADDRESS 16 Mirra Ave, Annapolis, Md | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 12/18/83 | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Conish | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10/10/2001

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 83 31584 | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARIAN Tyler Colborn HEISE | | | | 2a. DATE OF DEATH MONTH DAY YEAR DEC 13 1983 | | | |
| 3. SEX FEMALE | | | | 2b. HOUR P.M. | | | |
| 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 211 NORWOOD RD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Board of Education | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. | | | | 13b. COUNTY A.A. Co | | | |
| 13c. CITY OR TOWN ANNAPOLIS | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS 211 Norwood Rd 21401 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George W. Tyler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Phoebe | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 220-284802-A | | | |
| 17. INFORMANT ADDRESS same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the biliary tract (b) (Hatzkin tumor) (c) 1569 DUE TO, OR AS A CONSEQUENCE OF (b) 1569 DUE TO, OR AS A CONSEQUENCE OF (c) 1569 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1569 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19____, to 19____, that (I) (we) last saw the deceased alive on 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE Peter F. Verkouwen DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22b. DATE SIGNED 12/14/83 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUWEN MD | | | | 22d. ADDRESS 1419 FOREST DR ANNAPOLIS MD 21403 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 16, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY St. Anne's | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel ADDRESS 21401 ANNAPOLIS MD | | | | 25a. DATE REC'D. BY REGISTRAR DEC 16 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE James J. Grier | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM Joseph HELMS SR | | DECEMBER 07, 1983 | | 244 AM | |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Feb 2, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner | | 12b. KIND OF BUSINESS OR INDUSTRY Helm's Cafe |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Pasadena | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Helms | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk Gary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) MD 2 216-32-7129 | | 17. INFORMANT ADDRESS Karen Helms 11 Acton Pl., S. Annapolis 21401 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did/did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Dr. G. Helms</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 7845 OAKWOOD ROAD SUITE 200 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12-8-83 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balt. Md. | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE DEC 9 1983 John J. Conner | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mc Cully Funeral Home 3204 Mountair Rd. 21122 | | | | | |

FILED
DEC 9 1983
FBI - MEMPHIS

Cardiac arrest
M.I.

M. J. [Signature]

DEC 9 1983
FBI - MEMPHIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. FOR
STATE
REGISTRAR

REG. NO.

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|--|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William Hemsky</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>12-9-83</i> | | 2b. HOUR <i>5:20 P.M.</i> | | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>CAUCASIAN</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>7-15-99</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Iowa</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL County MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Annapolis</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ANNE ARUNDEL General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>electrucuan</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>picture</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Md.</i> | | 13b. COUNTY <i>A.A.Co.</i> | | 13c. CITY OR TOWN <i>Cape St. Claire</i> | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 13e. STREET ADDRESS / ZIP CODE <i>715 Fairway Dr. 21401</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>William Hemsky Sr.</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Horak</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>490 03 9915</i> | | 17. INFORMANT ADDRESS <i>204 Jamcia Dr.</i> <i>Betty J. Scherer Coco Beach Fla.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute and chronic respiratory failure</i> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>12/9/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>Dec. 13, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mountain View</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Mesa Arizona</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>Hardesty Funeral Home</i> | | | | ADDRESS <i>12 Ridgely Ave Annapolis, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>DEC 14 1983</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MEDICAL CERTIFICATION

RECEIVED
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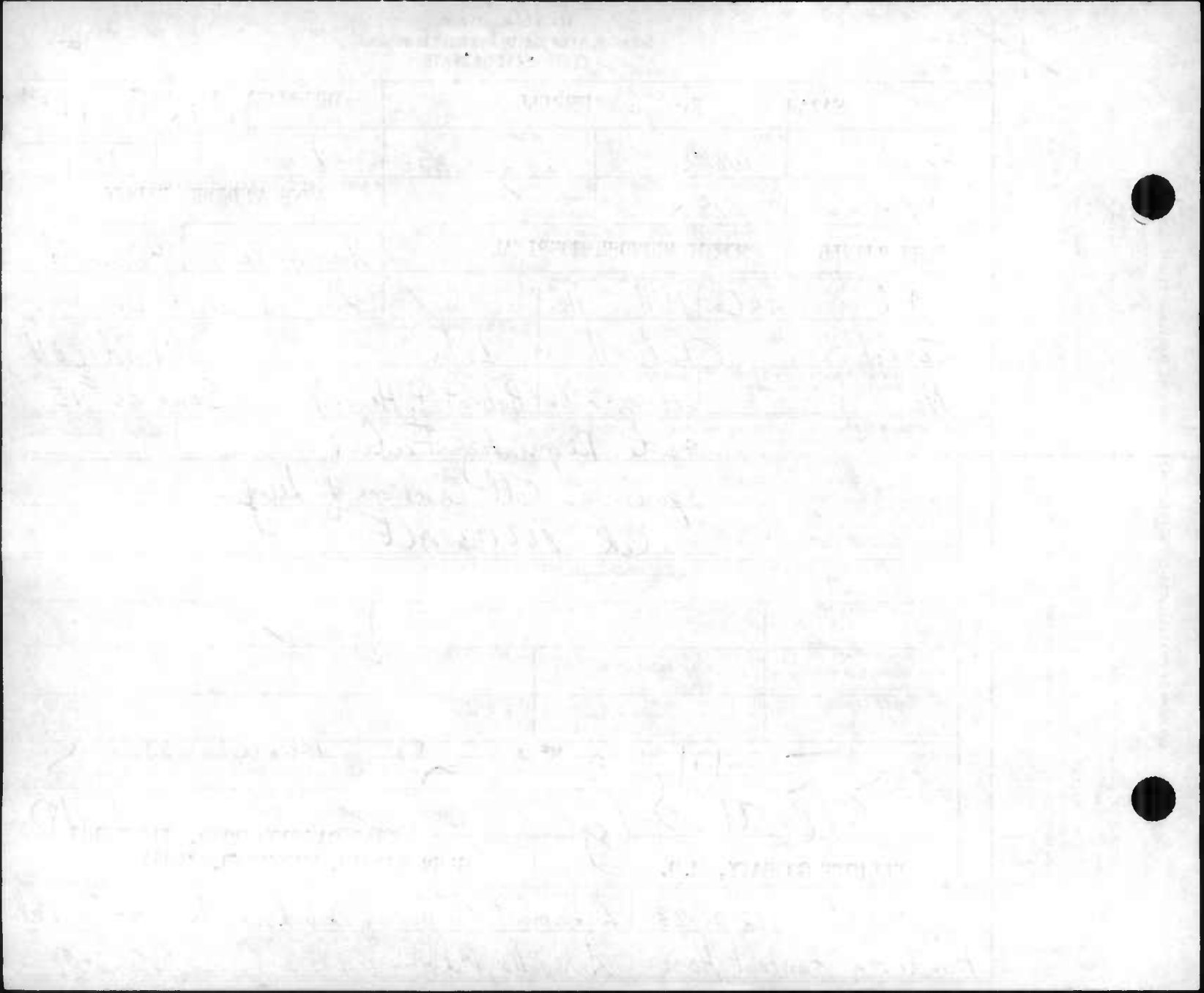
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

| | | | | | | |
|---|---|---|-----------------------------------|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST SARAH | MIDDLE Evelyn | LAST HERRELL | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 23 1983 | 2b. HOUR 12 M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12-28-1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOME, GIVE CITY AND STATE ADDRESS) NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY Household | |
| 13a. STATE Md. | | 13b. COUNTY AA Co | 13c. CITY OR TOWN Millersville | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 801 Cedarcroft Dr. P 2108 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Chadwell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Chadwell | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | |
| 16b. SOCIAL SECURITY NO. 214-30-2566 | | 17. INFORMANT Robert P. Herrell | | ADDRESS Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Squamous Cell Carcinoma of Lung</u> (c) <u>CHL PULMONACE</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/19/83</u> to <u>12/23/83</u> , that (I) (we) lost saw the deceased alive on <u>12/19/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE ELLIOTT GORBATY, M.D. | | DEGREE ATTENDING PHYSICIAN | | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/23/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND, 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12-26-83 | 23c. NAME OF CEMETERY OR CREMATORY Lakemont Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville AA Co Md. | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | ADDRESS Annapolis, Md. | | 25. DATE REC'D. BY REGISTRAR DEC 29 1983 | | |
| | | 26. REGISTRAR'S SIGNATURE Joan J. Connel | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

#5, FilmG587 1/5/83 kam
 1 - STATE REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BRIAN P. HISAMOTO | | 2a. DATE OF DEATH MONTH DAY YEAR 12-17-83 | | 2b. HOUR 2 A M | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR AUG 30 1980 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS. | |
| 10. CITY OR TOWN OF DEATH ARNOLD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1090 BRIGHTLEAF CT. | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 13a. STATE MARYLAND | | 13b. COUNTY ANNE ARUNDEL | | 13c. CITY OR TOWN ARNOLD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT W. HISAMOTO | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN T. SHERIDAN | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS ROBERT W. HISAMOTO (SAME AS 13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Hepatoma of the liver</u> 1550 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-17-83</u> , 19 <u>83</u> , to <u>12-17</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Jonathan M. Sutton</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED 12-14-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONATHAN M SUTTON | | 22e. ADDRESS 201 FORBES ST ANNAPOLIS, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE DEC. 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE CLINTON PRINCE GEORGES MD | | 24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 21 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Carney</u> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD KING HOW | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/9/83 | | | 2b. HOUR 9:05 A.M. | | | |
| 3. SEX MALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 12/25/06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | 6. AGE (IN YEARS LAST BIRTHDAY) # UNDER 1 YEAR MONTHS DAYS # UNDER 72 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IND. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A.C. | | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AAGH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES | | 12b. KIND OF BUSINESS OR INDUSTRY GEN. ELECTRIC | | | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN SEVERNA PARK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 282 OAK COURT 21146 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD C. HOW | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELE KING | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 041-09-3547 | | 17. INFORMANT ADDRESS WIFE 15 - 13 ABODE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 CARACIN Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ASELA, Atrial fibr | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8 19 83 , to present 19 83 , that (I) (we) last saw the deceased alive on 12/8 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE A. B. | | | | DEGREE MD | | | | 22c. DATE SIGNED 12/9 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BIERNE | | | | 22e. ADDRESS ANNAPOLIS MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 12/10/83 | | 23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREM | | 23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BART. MD | | | |
| 24. FUNERAL DIRECTOR NAME BARTANCO F.H. | | ADDRESS 501 RITCHIE HWY SEVERNA PARK | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31590

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} CLARION ^{MIDDLE} L. ^{LAST} HOWARD | | 2a. DATE OF DEATH MONTH DAY YEAR 12-28-83 | |
| 3. SEX FEMALE | | 2b. HOUR 9:30 P.M. | |
| 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 8 16 18 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOS ANGELES CAL | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH CROFTON | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CROFTON CONVALESCENT CENTER | | 12a. USUAL OCCUPATION (USUAL WORK FOR MOST OF WORKING LIFE) Teacher | |
| 12b. KIND OF BUSINESS OR INDUSTRY Public School | | 13a. STREET ADDRESS 1169 GREAT OAK CT. 21032 | |
| 13b. STATE MD. COUNTY A.A. | | 13c. CITY OR TOWN GROTONVILLE | |
| 14. FATHER'S NAME ^{FIRST} Arthur ^{MIDDLE} ^{LAST} Leatart | | 15. MOTHER'S MAIDEN NAME ^{FIRST} Goldie ^{MIDDLE} ^{LAST} Meyer | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 378-38-4078 | |
| 17. INFORMANT ADDRESS Alan J. Howard #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to, or as a consequence of, appearance of heart with infarction (c) Due to, or as a consequence of, years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28/83 10/18 1983, to 12/28 1983, that (I) (we) last saw the deceased alive on 12/28 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE [Signature] DEGREE | | 22c. DATE SIGNED 12/28/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C FRANK MD | | 22e. ADDRESS 7575 Ruthe Hwy - Glen Burnie MD 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12-29-83 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P. DE | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel | | 25a. DATE REC'D BY REGISTRAR JAN 03 1984 | |

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the methodology. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodate in acidic solution. The methodology involves measuring the rate of reaction at different temperatures and using the Arrhenius equation to determine the activation energy.

| Temperature (°C) | Rate of Reaction (mol/l.s) |
|------------------|----------------------------|
| 20 | 0.0012 |
| 30 | 0.0025 |
| 40 | 0.0050 |
| 50 | 0.0100 |
| 60 | 0.0200 |
| 70 | 0.0400 |
| 80 | 0.0800 |
| 90 | 0.1600 |
| 100 | 0.3200 |

The data shows that the rate of reaction increases with temperature. The activation energy of the reaction is 50 kJ/mol.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 9 1

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RODNEY B. HOWARD | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-27-83 | | 2b. HOUR 6³⁵ AM | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 5-13-19 | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | 13b. COUNTY A.A. | 13c. CITY OR TOWN ANNAPOLIS | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK HOWARD | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE BROIGDEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 213-12-2770 | | 17. INFORMANT ADDRESS BEVERLY TAYLOR 140 Conley Dr. Annapolis, Md. 21403 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CANCER OF Larynx**

1619

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

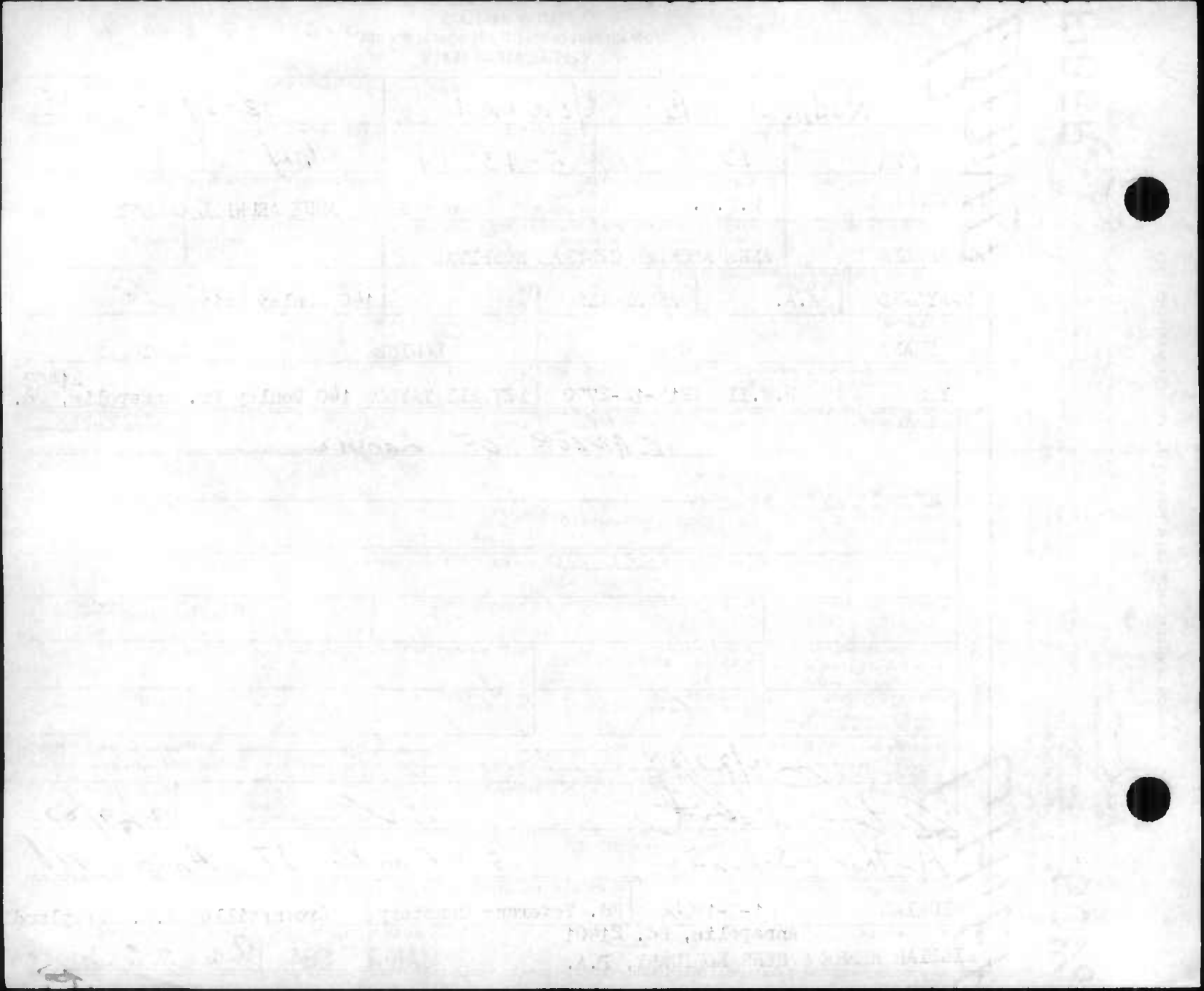
MEDICAL CERTIFICATION

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive 12/27/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) move the body after death. | | | |
| 22b. SIGNATURE A. Thur Schwartz | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 12/29/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Thur Schwartz | | 22e. ADDRESS 51 Franklin ST Annap MD | |

| | | | |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) BURIAL | 23b. DATE 1-3-1984 | 23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1984 | 25b. REGISTRAR'S SIGNATURE John J. Carver |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR <i>21061</i> | | | | | 83 31592 EST | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THEODORE AUGUSTUS HOWARD | | | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1983 | |
| 3. SEX M. | | 4. RACE B. | | 5. DATE OF BIRTH MONTH DAY YEAR OCT. 10-1901 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 82 | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NAME OF FACILITY UNKNOWN, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 8. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 82 | | |
| 13a. STATE MD. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ELIZAH HOWARD | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH CARROLL | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 319-10-0990 | | 17. INFORMANT ADDRESS Louise N. Howard Sapp A. 13E | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ADULT ONSET DIABETES MELLITUS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> AT WORK NOT WHITE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/24 19 83 to 12/24 19 83 , that (I) (we) last saw the deceased alive on 12/24 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Glenn F. Robbins | | DEGREE M.D. | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN F. ROBBINS, M.D. | | 22e. ADDRESS 1404 CRAIN HIGHWAY, SUITE 300 GLEN BURNIE, MARYLAND 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL | | 23b. DATE 12-28-83 | | 23c. NAME OF CEMETERY OR CREMATORY CPDAK HILL BALT. | | |
| 24. FUNERAL DIRECTOR NAME CE Hicks II | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE John J. [Signature] | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Richard Hume | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-2-83 | | | | 2b. HOUR MIN. 12 54 P | |
| 3. SEX M | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH DAY YEAR JUL 7 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH Ft. Meade | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimberly Community Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. AF. | | 12b. KIND OF BUSINESS OR INDUSTRY Gov. Ret. | |
| 13a. STATE MD | | 13b. COUNTY AA Co | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1701 Pineyard Trl | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas L Hume | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Same as 13 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES) 34-65 | | 17. INFORMANT Richard M. Hume | | ADDRESS Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 5712 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Hepatorenal Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Alcohol Cirrhosis with Liver Decompensation | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min 1 day Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Joey D. Zeliga | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 2 Dec 1983 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12-6-83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | | | ADDRESS Annapolis, Md | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE John D. Conner | |

MEDICAL CERTIFICATION

STATIONER'S COPY
RECEIVED
JAN 10 1907

My dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. [Name]
[Title]

50%
C.C. FOM
1/1



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31594

1- FOR
STATE
REGISTRAR

A/K/A Arlara

REG. NO.

| | | | | |
|--|----------------------------|---|------------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) ALARA P. ISAAC | | 2a. DATE OF DEATH MONTH DAY YEAR 12-12-83 | | 2b. HOUR 6-50 P.M. |
| 3. SEX Female. | 4. RACE Black. | 5. DATE OF BIRTH MONTH DAY YEAR 1-3-20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Aiken, S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH CROWNSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CROWNSVILLE HOSP. CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper |
| 13a. STATE MARYLAND | | 13b. COUNTY A.A. Co | 13c. CITY OR TOWN GIBSON ISLAND | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Purvis Peterson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLEO Patterson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT ADDRESS Larry Isaac 6824 Rover Dr. Jacksonville, Fl. 32208 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST, (Heart Failure)</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension - (A.S.C.V.D.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Major Depression - INVOLUTIONAL WITH Psychotic features -</u> | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11-28</u> , 19 <u>83</u> , to <u>12-12</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-12</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <u>mrl Borkhetaria</u> | | DEGREE M.D. | | 22c. DATE SIGNED 12-12-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.M.L. BORKHATARIA, M.D. | | 22e. ADDRESS CROWNSVILLE HOSP. CENTER. CROWNSVILLE Md-21032 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Dec. 18, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Beaverdam Baptist Church Cem, Aiken, S.C. | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA | | 25. DATE REC'D. BY REGISTRAR 19 1983 | | |
| | | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

UNITED STATES
NAVY
OFFICE OF THE SECRETARY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

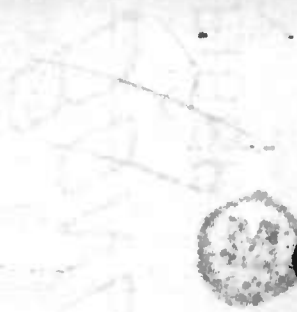
REG. NO.

EST

| | | | | | | | | | | | |
|---|--|---|--|---|--------------------|---|--|---|---|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) SARAH Lanona JENKINS | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 29, 1983 | | 2b. HOUR 653 PM | | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 6, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 105 Riviera Drive (21122) | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Solomon H. Johnson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adeleine Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT (Legal Guardian) Mrs. Mildred C. Johnson (same as #13) | | | | | | | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Coronary Arteriosclerosis Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ischemic heart disease</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Ischemic heart disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE <i>Jose M. Presbitero M.D.</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/3/83 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE M. PRESBITERO, M. D. | | | | 22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 107 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 3, 84 | | 23c. NAME OF CEMETERY OR CREMATORY Magothy Church Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pasaden A.A., MD. | |
| 24. FUNERAL DIRECTOR NAME A.B. Vinn | | | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1984 | | | |
| 24b. ADDRESS Singleton Funeral Home Glen Burnie, Md. | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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| | | | | | |
|---|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ALDEN Cornelius JOCELYN | | DECEMBER 24, 1983 | | 9:50 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. UNDER 1 YEAR | |
| Male | White | Nov. 21, 1903 | 80 YRS | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| New York | U.S.A. | | ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Oil Refining | | Oil Co. |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE |
| Maryland | | A.A. | Glen Burnie | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 6 Brownshade Drive, S.W. 21061 |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Cornelius F. Jocelyn | | Agnes Robertson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | |
| Yes | | W.W. I 218.03.2134 | Wife Marjorie Jocelyn Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> (b) <u>Respiratory Depression</u> (c) <u>ASIA</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASIA</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21a. INJURY OCCURRED | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION | |
| WHERE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>12/23/83</u> to <u>12/24/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we do not view the body after death, we so state.) | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| | | Jorge B. Ramirez, M.D. | | 12/25/83 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION |
| Burial | | Dec. 28, 83 | Glen Haven Mem Pk. | | Glen Burnie A.A. MD |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Singleton Funeral Home, Glen Burnie, MD | | DEC 28 1983 | | John J. Conner | |

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| 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 |
| 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 |
| 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 |
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| 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 |
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| 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 |
| 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 |
| 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 | 11/11/11 |

CONFIDENTIAL
INVESTIGATION REPORT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Alfred NMN Johnson | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-21-83 | | | |
| 3. SEX M | | | | 2b. HOUR 10 A.M. | | | |
| 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 21 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. GEN. HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer-Retired U.S.N.A. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ELIJAH JOHNSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY JEAN HENSON | | 13e. STREET ADDRESS 1820 F. Copeland 21401 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-44-9366 | | 17. INFORMANT M. ALFREDA JOHNSON SAMPAS 13E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1509 IMMEDIATE CAUSE (a) Carcinoma Esophagus DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12-20 19 83 to 12-21 19 83 , that (I) (we) last saw the deceased alive on 12-20 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Karl R. Holschuh | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12-21-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOLSCHUH, K R | | | | 22e. ADDRESS 16 Murray Ave. Annapolis, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-26-83 | | 23c. NAME OF CEMETERY OR CREMATORY PINE LAWN | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD | |
| 24. FUNERAL DIRECTOR C.E. HICKS III ANNAPOLIS-MD. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8331598

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) George M. JONES | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 13 83 | | | | 2b. HOUR 9:50 A M | |
| 3. SEX m | | 4. RACE w | | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self employed | | 12b. KIND OF BUSINESS OR INDUSTRY Bail Bondsman | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Edgewater | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4104 Cadle Creek Rd. 21037 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edwin P. Jones | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Lee | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-09-3292 | | 17. INFORMANT ADDRESS Maybelle Dorr Jones (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) the hospital attended the deceased from 10/28/82 to 12/13/83, that (1) the lost how the deceased alive on 19_____, and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (2) the did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE H. D. Goldstein | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/13/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard D. Goldstein, M.D. | | | | 22e. ADDRESS 205 Ridgley Ave., Annapolis, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-15-83 | | 23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, A.A., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Beall Funeral Home, Bowie, Maryland 20715 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to conduct an autopsy.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | Item #8 Film #G588 2/6/84 jp | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | REG. NO. | | EST 31599 | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROY CLARK KANE | | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 09, 1983 | | 2b. HOUR 4.56 PM | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 1-21-1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN | | 12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY ANNE ARUNDEL | | 13c. CITY OR TOWN PASADENA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 102 CLUB RD. 21122 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS KANE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA VINEYARD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-3616 | | 17. INFORMANT ADDRESS Mr. William M. Kane - 102 Club Rd. 21122 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CARDIAC Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Intermittent Coronary Heart Disease YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/12/82 to 12/9/83, that (I) (we) lost saw the deceased alive on 12-2-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE MARCELINO ALBUERNE M.D. | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/9/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCELINO ALBUERNE M.D. | | 22e. ADDRESS PASADENA MARYLAND 21122 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT | | 23b. DATE 12-13-83 | | 23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO, MD. | | | |
| 24. FUNERAL DIRECTOR NAME John J. L... - 7527 Harford Rd | | | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1983 | | 25b. REGISTRAR'S SIGNATURE John J. L... | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EDT

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|---------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN CHRISTINE (MILBURG) KEIL | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1983 | | 2b. HOUR PM 830 PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 12, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 71 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. A.A. Severn | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1431 Virginia Ave. (21144) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Milburg | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 067-38-9255 | | 17. INFORMANT ADDRESS Gordon Keil (same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arterial Disease DUE TO, OR AS A CONSEQUENCE OF (c) 3 month | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Renal Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE 83 12-24 19 83 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-24 19 83 to 12-24 19 83 that (I) (we) last saw the deceased alive on 12-24 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.) | | | | | | | |
| 22b. SIGNATURE Long S. Hsu M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D. | | | | 22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md. | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce F.H. 4001 Ritchie Hwy. | | | | 25. DATE RECEIVED BY REGISTRAR DEC 27 1983 | | 26. REGISTRAR'S SIGNATURE John J. Gance | |

101

RECEIVED 20, 1952

UNITED STATES DEPARTMENT OF AGRICULTURE

STATE OF ARIZONA

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

YUMA COUNTY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Robert Keller | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-16-83 | | 2b. HOUR 4³⁰ M |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 8-11-10 | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN BALTIMORE, GIVE STREET ADDRESS) ANNAPOLIS A.A. GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND | | 13b. COUNTY A.A. | 13c. CITY OR TOWN ANNAPOLIS | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1906 Lincoln Drive 21401 |
| 14. FATHER'S NAME FIRST MIDDLE LAST TOMMY KELLER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATILDA MARTIN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE VETERAN DATES) YES | | 16b. SOCIAL SECURITY NO. 428-09-2410 | 17. INFORMANT ADDRESS SARA KELLER 1906 Lincoln Dr. Annapolis, Md. 21401 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain infarction 4349 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 10 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 83 , to 12/16 , 19 83 , that (I) (we) lost saw the deceased alive on 12/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Gerard Blumel | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 12/17/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD CHURCH | | 22e. ADDRESS 8 EVELGREENE ROAD, SEVERNA PARK MD 21146 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 12-22-1983 | 23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland | | |
| 24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. DATE REC'D BY REGISTRAR DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Church | |

MEDICAL CERTIFICATION

12-14-85 4 2

Keller

Robert

13

2-11-10

B

VI

THE STATE OF TEXAS

COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE

STATE OF TEXAS

IN RE: THE ESTATE OF

ROBERT B. KELLER

DECEASED

VS.

JOHN A. KELLER

ADMINISTRATOR

Plaintiff

Defendant

Comes now the Plaintiff

and moves this Court

for an order

appointing the Plaintiff

as the Administrator

of the Estate of

Robert B. Keller

deceased.

And the Plaintiff

swears that the

above is true and

correct to the best

of his knowledge.

Subscribed and sworn to

before me this 12th day

of December, 1985.

Notary Public in and for

the State of Texas.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified of cause.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 3 3 1 6 0 2 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | |
| HELEN INEZ KENDALL | | | | | DECEMBER 19, 1983 | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| Female | | | | | White | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| MONTH DAY YEAR | | | | | YRS MONTHS DAYS HOURS MIN. | | | | |
| 04 23 1896 | | | | | 87 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| Maryland | | | | | U.S.A. | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| | | | | | ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | |
| GLEN BURNIE | | | | | NORTH ARUNDEL HOSPITAL | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Housewife | | | | | | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | | | |
| Maryland | | | | | Kent | | | | |
| 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| Rock Hall | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS | | | | | 13f. STREET ADDRESS | | | | |
| | | | | | Rural 21661 | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | |
| Charles Henry Jones | | | | | Hosanna Reed | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| No | | | | | 215-20-1100 | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| | | | | | Melvin M. Kendall, Queenstown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic Heart Disease</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| Days _____ years _____ | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY | | | | |
| | | | | | HOUR A.M. MONTH DAY YEAR | | | | |
| | | | | | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21f. LOCATION | | | | |
| | | | | | STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>12-9-1983</u> to <u>12-19-1983</u> , that (I) (we) lost saw the deceased alive on <u>12-19-1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | |
| 22c. DATE SIGNED | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| JACK I. STERN, M.D. | | | | | 300 HOSPITAL DRIVE, #135 GLEN BURNIE, MARYLAND 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | | | |
| Burial | | | | | 12/22/83 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION | | | | |
| Wesley Chapel Cem. | | | | | CITY OR TOWN COUNTY STATE | | | | |
| Rock Hall Kent MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | |
| NAME ADDRESS | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Tom Helfenbein Funeral Homes, Chester, Md. | | | | | DEC 30 1983 John J. Carver | | | | |

2020-00-01

1-1-2020



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 6 0 3

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fannie Davis Kent | | | 2a. DATE OF DEATH MONTH DAY YEAR December 23, 83 | | | 2b. HOUR M 12 noon | |
| 3. SEX F | | 4. RACE Bl. | | 5. DATE OF BIRTH MONTH DAY YEAR 6 10 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Galesville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (AT HOME) 929 Benning Road Galesville 20765 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Galesville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel Davis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Weston | | 13e. STREET ADDRESS 929 Benning Road | | 21054 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-05-0557 | | 17. INFORMANT Monzell Kent | | ADDRESS Same Husband | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 21</u> , 19 <u>77</u> , to <u>October 13</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Aug 10/13</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>William B. Freedberg</u> | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W-B-Freedberg</u> | | MD | | 22e. ADDRESS 134 Duessville Road, West River 20778 | | | |

| | | | | | | | |
|--|--|-------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-29-1983 | | 23c. NAME OF CEMETERY OR CREMATORY EBENEZER A.M.E. CHURCH | | 23d. LOCATION CITY OR TOWN COUNTY STATE Galesville A.A. Maryland | |
|--|--|-------------------------|--|--|--|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401 | | 25. DATE REC'D. BY REGISTRAR JAN 4 1984 | | 26. REGISTRAR'S SIGNATURE <u>John J. Lohr</u> | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 6 0 4

1. FOR
STATE
REGISTRAR

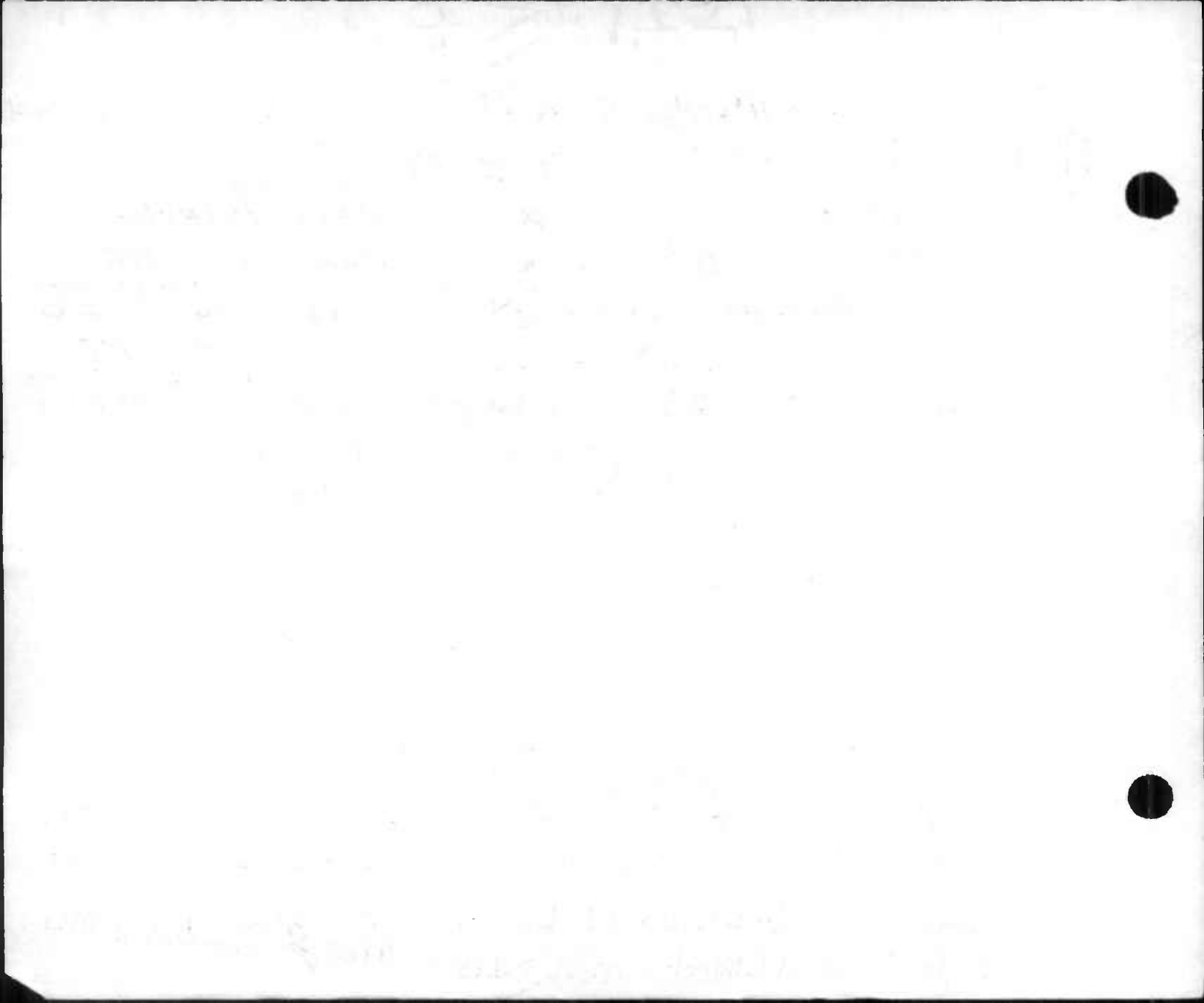
REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) KING HELENE M. KING. | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 27 83 | | 2b. HOUR 0015AM |
| 3. SEX Female | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 09 14 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY? USA. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ARTHUR HOSPITAL | | 12a. USUAL OCCUPATION (LAST OF WORK FOR MOST OF WORKING LIFE) BEAUTICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY RET. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN CHEVY CHASE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE Chevy Chase, MD 3804 Inverness Dr. 20815 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN AMBROSE DOMONIE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAZANO | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 225-05-0804 | | 17. INFORMANT ADDRESS Mary Ann Iverson - Crofton MD 21114 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I S/P Radiation to Sq Cell Ca mouth & Breast | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26 1983 to 12/27 1983 , that (I) (we) lost saw the deceased alive on 12/26 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death | | | | | |
| 22b. SIGNATURE Michael J. LaPenta | | DEGREE MD | | 22c. DATE SIGNED 12/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MILITARE J. LaPenta | | 22e. ADDRESS 703 GIDDINGS AVE ANNAPOLIS MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Dec 28 1983 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG MD | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD | | 25a. DATE REC'D BY REGISTRAR DEC 29 1983 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTER

| | | | | | | | | | | | |
|--|--|---|---|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Hazel Kathleen Kleeberg | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 3 1983 | | | 2b. HOUR 10:30 AM | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 15, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS 53 | | 8. UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3148 Harness Creek Rd | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY Office | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Annapolis | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3148 Harness Creek Rd 21403 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Garner | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Sheckells | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 212-26-4708 | | 17. INFORMANT William Kleeberg ADDRESS same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3352 IMMEDIATE CAUSE (a) Cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 78 to 19 83 , that (I) (we) last saw the deceased alive on 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Nicholas Capozzoli DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12/5/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NICHOLAS CAPOZZOLI | | | | | | 22e. ADDRESS 25 Shaw St. Annapolis MD 21401 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Dec. 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD | | | | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel ADDRESS Annapolis MD | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 7 1983 | | | 25b. REGISTRAR'S SIGNATURE James G. Carter | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



The following is a list of the
 names of the persons who
 were present at the meeting
 held on the 1st day of
 January 1880 at the
 residence of Mr. J. H.

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 names of the persons who
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 83 31606 | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Amelia Kolodiej | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 15 '83 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 12 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Manor Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home Maker | |
| 13a. STATE Md | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William T. Anderson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne | | 13e. STREET ADDRESS 634 Bruce Street 21225 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-6296 | | 17. INFORMANT ADDRESS Francis C. Kolodiej Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Lymphatic Leukemia</u> 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-27</u> , 19 <u>78</u> , to <u>12-15</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12-7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Dr. M. Pearlman</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. M. Pearlman</u> | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-19-83 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce 4001 Ritchie Hgwy Balto, Md | | | | 25. DEC 19 1983 REGISTRAR'S SIGNATURE <u>John J. Gough</u> | | | |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8331607 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ALBERT KONOPNICKI | | | | 2a. DATE OF DEATH MONTH DAY YEAR DEC 4, 1983 | | 2b. HOUR 2255 P | |
| 3. SEX MALE | | 4. RACE CAUCASION | | 5. DATE OF BIRTH MONTH DAY YEAR SEPT 9, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEWARK, NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNF ARUNDELL MD. | |
| 10. CITY OR TOWN OF DEATH FT MEADE, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KIMBROUGH ARMY COMMUNITY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronics Prod Planner | | 12b. KIND OF BUSINESS OR INDUSTRY Missile | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN WASH., D.C. | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS US SOLDIERS HOME 3700 N. CAPITOL ST. N.W. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LEON KONOPNICKI | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST STELLA BOSTIKA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 9-32 - 9-35 520-28-2575 | | 17. INFORMANT ADDRESS GLORIA HARRIS (MRT) SOLDIERS' HOME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest.</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>John B. Theobalds</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/4/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN B. THEOBALDS | | | | 22e. ADDRESS Kimbrough Army Community Hospital Ft. Meade, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/8/83 | | 23c. NAME OF CEMETERY OR CREMATORY U.S. Soldier's & Airmen's | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, Dist. of Col. | |
| 24. FUNERAL DIRECTOR NAME MURPHY FUNERAL HOME - FALLS CHURCH, VA. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | |

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

[Large, stylized, handwritten or stamped text, possibly reading "DRAFT" or similar.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 327-3333.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

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|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | OLGA MARGARET KOPEC | | DECEMBER 06, 1983 | | 206 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| female | | white | | 10 5 14 | | 69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Delaware | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Agent | | Real Estate | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21122 | |
| Md. A.A. Pasadena | | | | | | 1270 Rockhill Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Anthony Korczynski | | | | Mary R. Rudolf | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | 215 03 0220 | | Charles T. Kopec (same as 13E) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>M. Kopec</u> | | | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Kopec</u> | | | | 22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| burial | | 12/9/83 | | Holy Cross Cem. | | BrooklynPk. A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| George J. Gonce | | | | 4001 Ritchie Hwy. Baltimore Md. 21225 | | DEC 13 1983 <u>John J. Canish</u> | |

BP



OLGA

MARGARET HOPE

DEC

DE 1982

UNITED STATES DEPARTMENT OF JUSTICE

Handwritten signature or name

UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20530

DEC 1982

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

| | | | | | |
|--|-----------------------|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph A. Langer | | | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 6 19 83 | | 2b. HOUR M |
| 3. SEX M | 4. RACE CAU | 5. DATE OF BIRTH MONTH DAY YEAR 1 19 32 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 51 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Johnstown Pa | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dir. Civil. Def. | 12b. KIND OF BUSINESS OR INDUSTRY GOUT. |
| 13a. STATE Md | | | 13b. COUNTY AD. | 13c. CITY OR TOWN SEVERNA PK. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph A. Langer, Sr | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma DASche | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. KOREA, Viet Nam 171-32-6898 | | 17. INFORMANT CLARA A. LANGER (same as 13) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIAC Arrest. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE William P. Jones, M.D. | | TITLE (SPECIFY) Deputy | | DATE SIGNED 7 Dec 83 | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | ADDRESS 695 America Ct Davidsonville 21035 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL | | 23b. DATE Dec. 9, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM. | |
| 24. FUNERAL DIRECTOR NAME ROBERT S. BAERANCO | | ADDRESS 501 RITCHIE HWY. SEVERNA PARK, MD. | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | |
| | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA. | |



RECEIVED
JAN 10 1934

Mr. J. H. [unclear]

Jan 10 1934

X

W. B. A.

Mr. J. H. [unclear]

Mr. J. H. [unclear]

Mr. J. H. [unclear]

Mr. J. H. [unclear]

Mr. J. H. [unclear]

Mr. J. H. [unclear]

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✓

William J. [unclear]

RECEIVED
JAN 10 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsa Elizabeth LAYDEN | | 2a. DATE OF DEATH MONTH DAY YEAR 12/20/83 | | 2b. HOUR 2:30 M | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 5 21 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN Edgewater | |
| 14. FATHER'S NAME FIRST MIDDLE LAST R. Dudley Layden | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Meade | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO | |
| 16b. SOCIAL SECURITY NO. 212-26-2145 | | 17. INFORMANT Elsie M. Layden | | ADDRESS Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 PERFORATED VISCUS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. CARCINOMA OF LUNG, METASTATIC TO MEDIASTINUM & BRAIN | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION CITY OR TOWN COUNTY STATE | | 21g. LOCATION CITY OR TOWN COUNTY STATE | | 21h. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11-11-1973, to 12-20-1983, that (1) (we) lost saw the deceased alive on 12-20-1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE Edward S. Beck M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 12/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward S. Beck M.D. | | 22e. ADDRESS 1616 Forest Drive, Annapolis, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK IF) Burial | | 23b. DATE Dec 23, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY All Hallows Church Cem | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Bridgville AA MD | | 23e. DATE REC'D. BY REGISTRAR 23 1983 | | 23f. REGISTRAR'S SIGNATURE John J. Givier | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD | | ADDRESS | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 6 1 1

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ursula W Lee | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 16 83 | | 2b. HOUR 1340 M | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2 8 33 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 13a. STATE MD | 13b. COUNTY A.A. | 13c. CITY OR TOWN Annapolis | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13. STREET ADDRESS Broad Neck Rd, Lot 35 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Kurt Wilhelm Hofmann | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ottilie | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-28-8011 | | 17. INFORMANT Paris Lee | | |
| | | | | ADDRESS Same as #13 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

1509 IMMEDIATE CAUSE (a) esophageal carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b) COPD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) asthma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 81 to 12/16 19 83, that (I) (we) last saw the deceased alive on 12/16 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE [Signature] | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 12/12/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIA PLUCIS | | 22e. ADDRESS 1571 RITCHIE HIGH ANNUL | |

| | | | |
|---|---------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Dec. 20 1983 | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD | | 25. DAY RECEIVED BY REGISTRAR DEC 21 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. *Aspidiotus perniciosus* Comstock
2. *Aspidiotus perniciosus* Comstock
3. *Aspidiotus perniciosus* Comstock
4. *Aspidiotus perniciosus* Comstock
5. *Aspidiotus perniciosus* Comstock
6. *Aspidiotus perniciosus* Comstock
7. *Aspidiotus perniciosus* Comstock
8. *Aspidiotus perniciosus* Comstock
9. *Aspidiotus perniciosus* Comstock
10. *Aspidiotus perniciosus* Comstock

11. *Aspidiotus perniciosus* Comstock
12. *Aspidiotus perniciosus* Comstock
13. *Aspidiotus perniciosus* Comstock
14. *Aspidiotus perniciosus* Comstock
15. *Aspidiotus perniciosus* Comstock
16. *Aspidiotus perniciosus* Comstock
17. *Aspidiotus perniciosus* Comstock
18. *Aspidiotus perniciosus* Comstock
19. *Aspidiotus perniciosus* Comstock
20. *Aspidiotus perniciosus* Comstock

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

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| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) STANLEY J. LEONARD, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 23, 1983 | | | 2b. HOUR A 10:10 M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY A.A.Co. | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 348 Shady Lane Rd. Pasadena, Md. 21122 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George ----- Leonard | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah ----- Stone | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-8371 | | 17. INFORMANT ADDRESS Mrs. Ella M. Leonard, Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic Ca. Adenocarcinoma of the colon</u> (c) <u>attestation of (b) lung</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASHD; Old CVA.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION <u>N/A</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>N/A</u> | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 6, 1983</u> to <u>Dec. 23, 1983</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 23, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Benjamin A. de Guzman, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>12/23/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN A. deGUZMAN, M.D. | | | | 22e. ADDRESS 325 HOSPITAL DRIVE, #108 GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, Mt. & Ticken Rds. Md. 21122 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified in one of the following ways:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

Helen Mary Levay

REG. NO.

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|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>HELEN MARY LEVAY</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>DECEMBER 25, 1983</i> | | 2b. HOUR <i>0819 AM</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 8, 1917</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH <i>GLEN BURNIE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>NORTH ARUNDEL HOSPITAL</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL COUNTY MD.</i> | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>Md.</i> | | | 13b. COUNTY <i>A.A.</i> | | 13c. CITY OR TOWN <i>Pasadena</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Akonom</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Stephanie Lentowski</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-10-4666</i> | | 17. INFORMANT ADDRESS <i>Mary Herbert 8545 Summit Rd. (21122)</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic Heart disease</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immed</i> <i>Immed</i> <i>Years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 25, 1983</i> to <i>Dec 25, 1983</i> , that (I) (we) last saw the deceased alive on <i>Dec 25, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <i>Dr. Ira Kaplan</i> | | DEGREE | | 27. DATE SIGNED <i>12/25/83</i> | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. IRA KAPLAN</i> | | 22e. ADDRESS <i>7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>Burial</i> | | 23b. DATE <i>12/29/83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i> | | |
| 24. FUNERAL DIRECTOR NAME <i>George J. Gonce</i> | | 25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1983</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i> | | |
| 23d. LOCATION CITY OR TOWN <i>Balto.</i> | | 23e. COUNTY <i>Balto.</i> | | 23f. STATE <i>Md.</i> | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST WILLIAM J LEWIS J.R. | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 30, 1983 | | 2b. HOUR 455 PM | |
| 3 SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 5 14 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.A.V. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | 13b. COUNTY A.A. COUNTY | | 13c. CITY OR TOWN SEVERN | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM J. LEWIS SR. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OCTAVIA UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 460-20-6059 | | 17. INFORMANT ADDRESS ANNIE LEWIS 710 DOROL COURT 21144 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 2506 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus - severe Vascular, eye, kidney organ damage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u> PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (We) attended the deceased from 19 81 to 12/30 19 83, that (I) (We) last saw the deceased alive on December 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIOTT GORBATY, M.D. | | | | 22c. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061 | | 22d. DATE SIGNED 1/02/83 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11-5-84 | | 23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VET. | | 23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME E.L. PHILLIPS 1721 NORTH MONROE ST. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 - 1984 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonappers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be consulted.DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Frederick William Maennle | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 21 Nov. 1983 | | 2b. HOUR 3:25^A M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personal director | | 12b. KIND OF BUSINESS OR INDUSTRY CONED | | | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Arnold | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 481 Colonial Ridge Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wendelin Maennle | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Christ | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) WWI & WWII | | | | 16b. SOCIAL SECURITY NO. 050 07 6038 | | 17. INFORMANT ADDRESS Frances M. Kennedy-daughter Same as # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CMA 5070 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration Pneumonia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 83/10/26 , 19 83 , to 11/21/ , 19 83 , that (I) (we) lost saw the deceased alive on 11/20/ , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Recep Erol | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-21-1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Recep Erol, M.D., P.A. | | | | | | 22e. ADDRESS 325 Hospital Dr #104 Glen Burnie, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 11-21-83 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. Chief | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002 | | | | | | | | | | | | | |

BP

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60-61-11

K. S. Mehrotra, D. S. Chandra, K. K.

Item #2b Film #G588

2/6/84 jp

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jack Beason Marshall | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 18, 1983 | | 2b. HOUR P 5:00 M |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hunkers Pa. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH Deale | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5933 Deale Beach Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Service | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt |
| 13a. STATE Md. | | 13b. COUNTY A.A. Co. | 13c. CITY OR TOWN Deale | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John R. Marshall | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Beason | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 43-51 | | 17. INFORMANT ADDRESS Gertrude Marshall 5933 Deale B.Rd. Deale, Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1459

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (b), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION Feb 1983 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ORAL CARCINOMA | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from Feb 1982 to Dec 1983, that (II) (we) lost saw the deceased alive on 12-28-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Charles F. Converse | | DEGREE MD. | 22c. DATE SIGNED 12-19-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES F. CONVERSE | | 22e. ADDRESS 5 Cedar Point, Severna Park Md | |

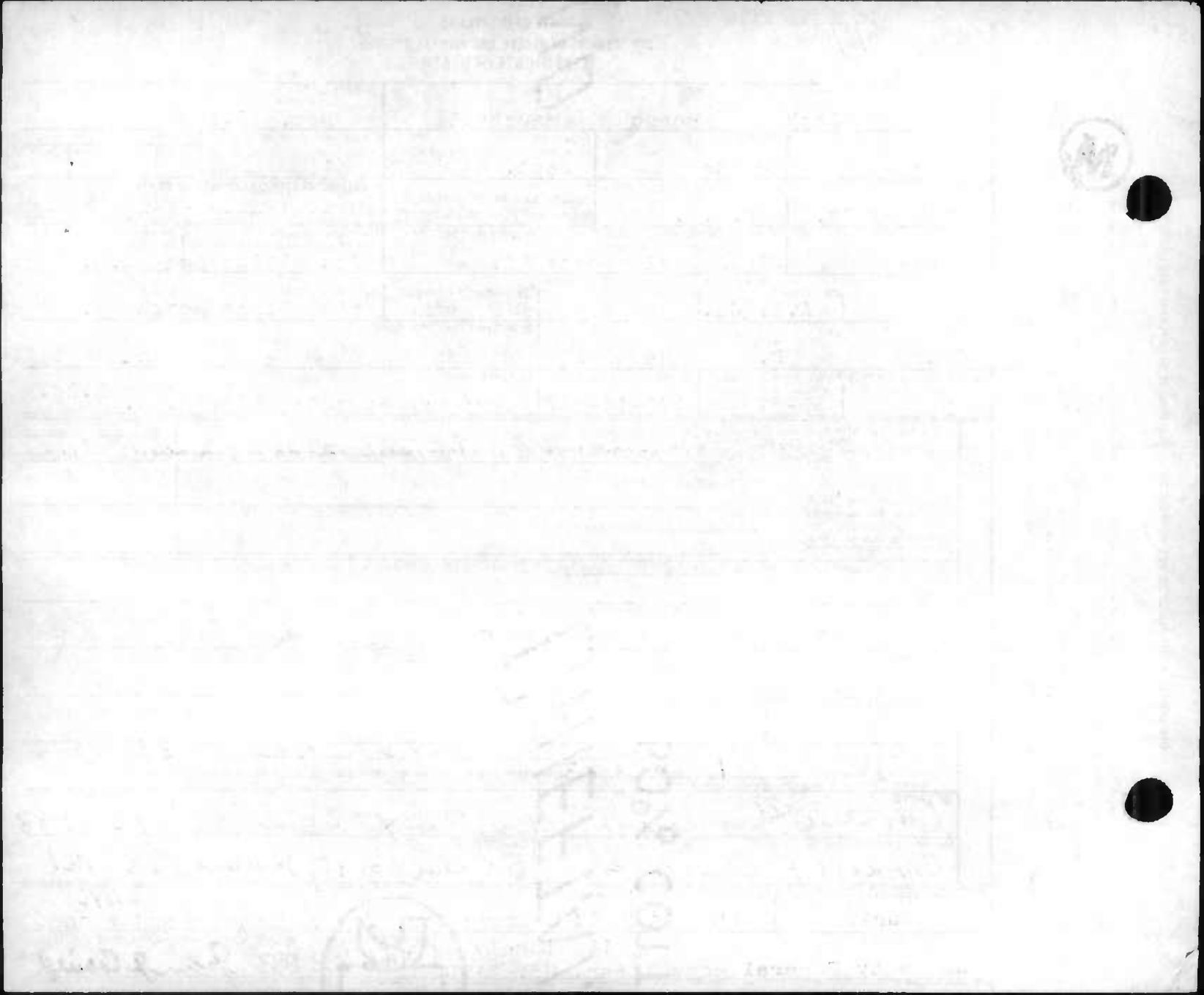
| | | | |
|--|-----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12/21/83 | 23c. NAME OF CEMETERY OR CREMATORY Mt Lebanon Cem. Tarrs Westmoreland Penna. | 23d. LOCATION CITY OR TOWN COUNTY STATE 21146 |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | ADDRESS 12 Ridgely Ave Ann. Md. 21401 | 25. DATE REC'D. BY REGISTRAR DEC 22 1983 |
| | | 26. REGISTRAR'S SIGNATURE John J. Converse | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

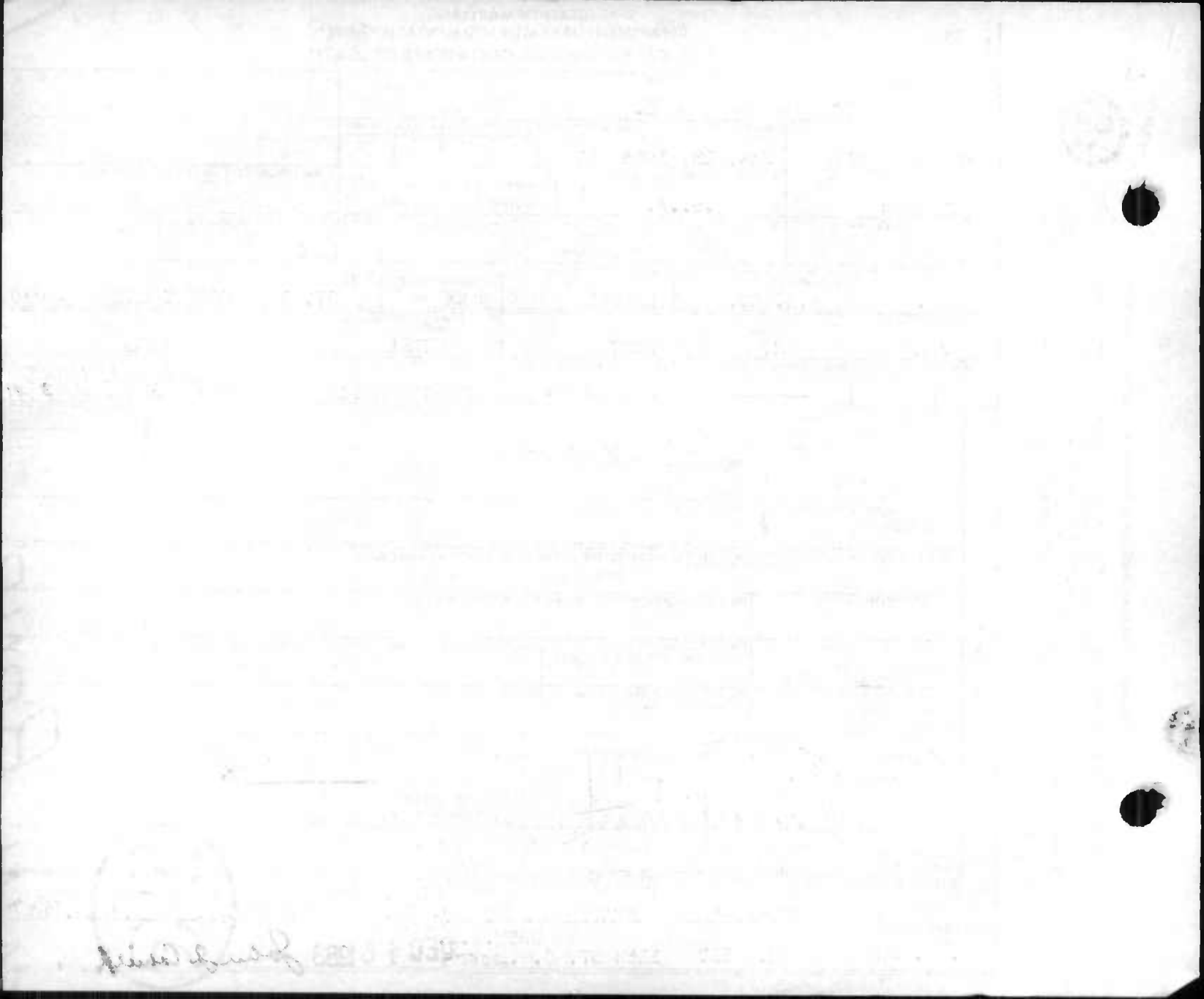
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

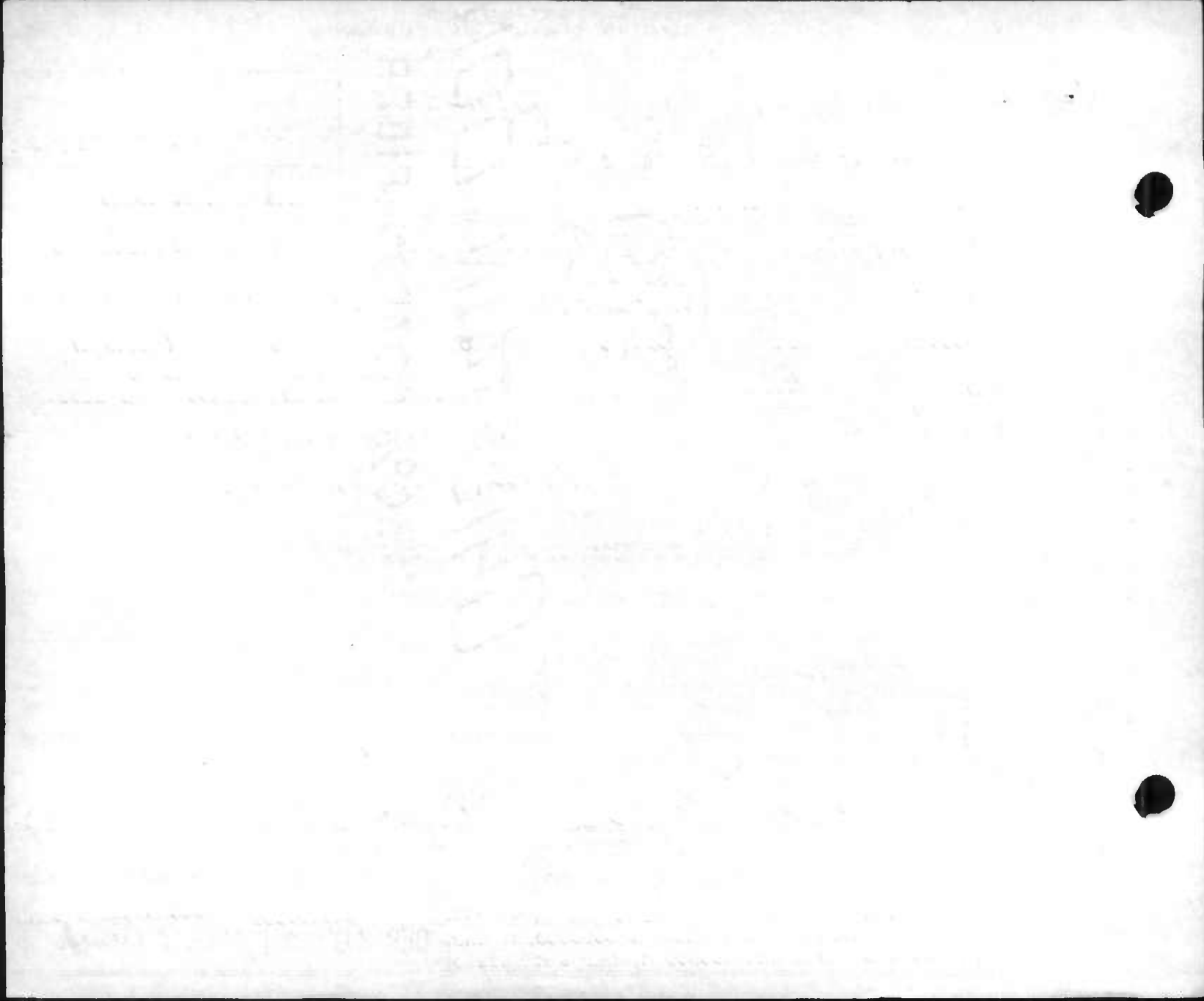
| | | | | | | |
|--|------------------|---|---|---|--------------------------------|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8 23 1983 | | 2b. HOUR M | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2c. DATE PRONOUNCED DEAD 12 3 83 | | 2d. HOUR M |
| Dorothy E. Martin | | | | | | 1:07P |
| 3 SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 25, 1926 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY? U.S..A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD. |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) woods near Forest Haven | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY NONE |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY A.A. CO. | | 13c. CITY OR TOWN LAUREL | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS RT. 198 FOREST HAVEN 20810 | | 14. FATHER'S NAME FIRST MIDDLE LAST JOHN H. MARTIN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL RIDDLE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-46-9421 | | 17. INFORMANT ADDRESS CALVIN MARTIN 2509 VALLEY DALE BIRMINGHAM, ALA 35244 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Undetermined</u> 79999 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a) stating the under- } lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Deputy chief | | DATE SIGNED 12/4/83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | ADDRESS 111 Penn St. Balto., MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-11-1983 | | 23c. NAME OF CEMETERY OR CREMATORY BRYAN MEM. PRESBY. CH. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BIRMINGHAM, JEFFER. ALA. 35209 |
| 24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. | | ADDRESS 517 11th ST. S.E. 2000 | | 25a. DATE REC'D. BY REGISTRAR DEC 16 1983 | | |
| | | 25b. REGISTRAR'S SIGNATURE  | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73
(VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 31518 | |
|--|--|--------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mildred U. Mather | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 19 12 29 83 | | | | 2b. HOUR M 0646 | |
| 3. SEX Female | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH DAY YEAR 11 9 98 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 85 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 12 29 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Nurses Aid | |
| 13a. STATE MD. | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Pikesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4737 Old Court Road 21208 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Henry Michael | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Mae (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 214-20-5389 | | 17. INFORMANT Mrs. Jean Phipps ADDRESS 462 Cedar Haven Road Arnold, Md. 21012 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Electrolyte Imbalance (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE William P. Jones M.D. Deputy | | | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | DATE SIGNED 12-29-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12-31-83 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore Maryland | |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, Maryland 21133 | | | | | | 25. REG. BY REGISTRAR DEC 30 1983 | | | 25. REGISTRAR'S SIGNATURE John J. Chish | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

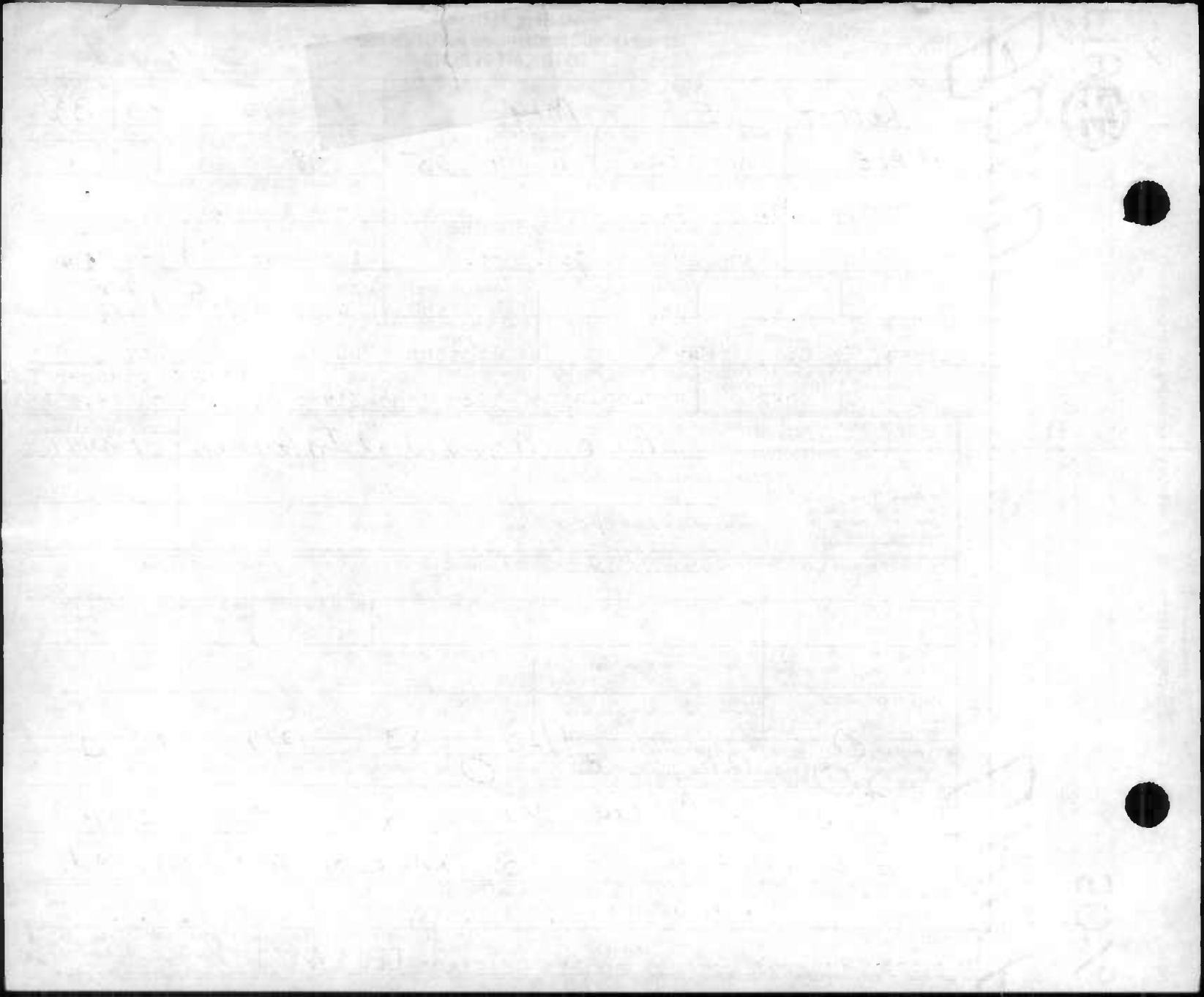
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

31017
31619

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) Robert E May | | 2a. DATE OF DEATH MONTH 12 DAY 9 YEAR 83 | | 2b. HOUR 3:53 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 11 DAY 9 YEAR 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY Law Firm | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Harwood | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE O. LAST May | | 15. MOTHER'S MAIDEN NAME FIRST Johanna MIDDLE Lyons LAST May | | 17. INFORMANT ADDRESS 122 Bayshores Rd. Alice Jane Fiveash, Va. Beach Va. 23451 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 4100 NONE | | 17. INFORMANT ADDRESS 122 Bayshores Rd. Alice Jane Fiveash, Va. Beach Va. 23451 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 Acute Myocardial Infarction IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 4/20 19 83 , to 12/9 19 83 , that (2) (we) last saw the deceased alive on 12/1 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If (s) did not view the body after death, so state). | | | | | | | |
| 22b. SIGNATURE Euse W Cole III | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/9/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE III | | 22e. ADDRESS 51 FRANKLIN ANNAPOLIS Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. 1. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md. P.G. | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Annapolis Md. 21401 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

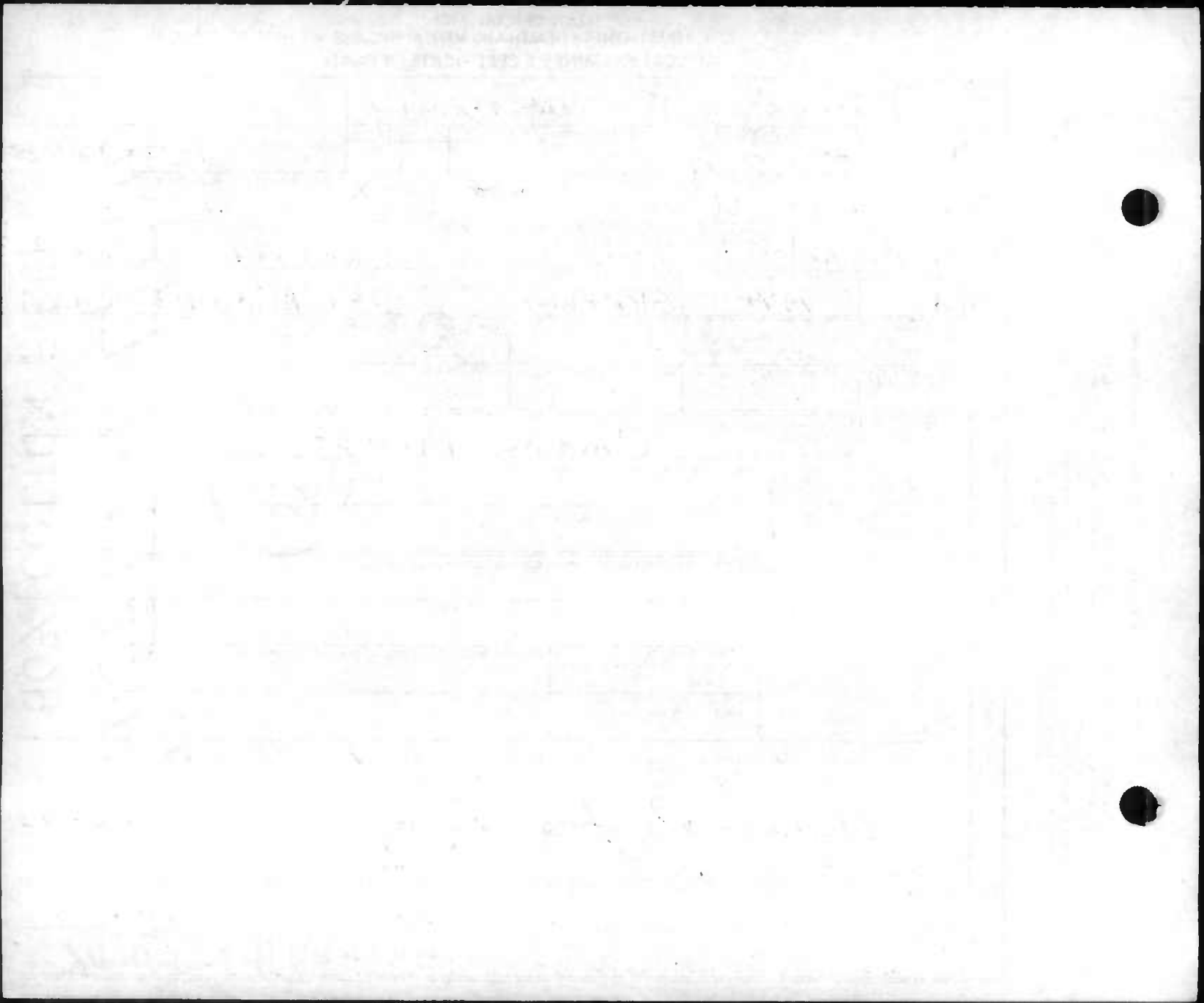
BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|---------------------------------|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) PATRICK J Mc Govern | | 2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input checked="" type="checkbox"/> 19 | | 2b. HOUR M |
| 3. SEX M | 4. RACE CAU. | 5. DATE OF BIRTH MONTH 5 DAY 27 YEAR 19 | 6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS. | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boston MA. | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 144 Midland Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired |
| 13a. STATE MD. | | 13b. COUNTY AA. | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST John MIDDLE T. LAST McGovern | | 15. MOTHER'S MAIDEN NAME FIRST Cora MIDDLE E. LAST LaBonte | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II | | 17. INFORMANT Argyle I. Tucker, Same as 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 Cardiac Arrest. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE William P. Jones | | TITLE (SPECIFY) M.D. Registry | | DATE SIGNED 12-28-83 |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | ADDRESS Annapolis, MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 30 Dec 1983 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | 23d. LOCATION CITY OR TOWN Baltimore | COUNTY Baltimore |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1983 | | |
| | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or kept, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| CONSTANCE E. BISER MILLER | | | | 12 28 83 6 P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | WHITE | | MAY 9 1906 | | 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | USA. | | | | ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ANNAPOLIS | | 309 MELVIN AVE | | MGR. PHOTO SHOP | | PHOTOGRAPHY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? | | | |
| 13a. STATE | | | | 13c. CITY OR TOWN | | | |
| MD. | | | | ANNAPOLIS | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | |
| IRA E. BISER | | | | IRENE C. WALTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | |
| NO | | 216 14 5113 | | BARBARA S. LAYTON | | 12 WAINWRIGHT DR ANNAPOLIS MD 21401 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac pulmonary and | | | | | | | |
| 4029 DUE TO, OR AS A CONSEQUENCE OF HASCVD | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF COPD | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 12/28/83 to 12/29/83, that (1) (we) last saw the deceased alive on 12/28/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| MICHAEL J. LaPENTA | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 12/29/83 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22d. ADDRESS | | | |
| MICHAEL J. LaPENTA | | | | 783 G. DUDINGS A. ANNAPOLIS MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| CREMATION | | 12/29/83 | | CEDAR HILL CREM. | | SUITES MD PG. MD | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| JOHN M. TAYLOR SONS ANNAPOLIS MD | | | | JAN 03 1984 | | [Signature] | |

BP

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it is the first time that the President has written to the Congress since the beginning of his administration. The letter is a very long one, and it covers a wide range of topics. It begins with a discussion of the state of the Union, and then goes on to discuss the various problems that the country is facing. The President discusses the issue of slavery, and the need for reform. He also discusses the issue of the Civil War, and the need for a strong government. The letter is a very important document, as it is the first time that the President has written to the Congress since the beginning of his administration.

2. The second part of the document is a letter from the Secretary of the Treasury to the Congress, dated January 1, 1863. It is a very important document, as it is the first time that the Secretary has written to the Congress since the beginning of his administration. The letter is a very long one, and it covers a wide range of topics. It begins with a discussion of the state of the Treasury, and then goes on to discuss the various problems that the country is facing. The Secretary discusses the issue of the Civil War, and the need for a strong government. The letter is a very important document, as it is the first time that the Secretary has written to the Congress since the beginning of his administration.

3. The third part of the document is a letter from the Secretary of the Interior to the Congress, dated January 1, 1863. It is a very important document, as it is the first time that the Secretary has written to the Congress since the beginning of his administration. The letter is a very long one, and it covers a wide range of topics. It begins with a discussion of the state of the Interior, and then goes on to discuss the various problems that the country is facing. The Secretary discusses the issue of the Civil War, and the need for a strong government. The letter is a very important document, as it is the first time that the Secretary has written to the Congress since the beginning of his administration.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HAZEL G. MILLER | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-30-83 | | | 2b. HOUR M 11 | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 3-23-15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel, MD | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Insurance | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Green Garner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Virginia Mayo | | 13e. STREET ADDRESS 701 Glenwood St. 21401 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-05-0523 | | 17. INFORMANT ADDRESS R.Scottie Miller (same as 13e) | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

1629 IMMEDIATE CAUSE (a) Ca Cerv

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19____, to 11/30/83 , 19____, that (I) (we) last saw the deceased alive on 11/30/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE ATTENDING PHYSICIAN | | 22c. DATE SIGNED 11/30/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/3/83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME [Signature] ADDRESS 1212 West St. | | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 7 1983 [Signature] | | | |
| Beall-Evans Funeral Home, Annapolis, Md. | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1911

11 30-82

REPORT OF THE COMMISSIONER OF THE LAND OFFICE
ON THE LANDS BELONGING TO THE STATE

PO%
88

100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Regs 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 19a&b film 587 | | | | STATE OF MARYLAND | | 8 3 3 1 6 2 3 | |
|--|--|---|--|---|--|--|--|
| FOR 1. STATE-30-84 cn REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| JAMES WARRINGTON MOORE, Sr. | | | | DECEMBER 12, 1983 | | | |
| 3. SEX Male | | | | 2b. HOUR 7:25 PM | | | |
| 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 18, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman (ret) | | | | 12b. KIND OF BUSINESS OR INDUSTRY Oscar Mayer Meats | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne | | 13c. CITY OR TOWN Severna Pk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William K. Moore | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn L. Warrington | | 13e. STREET ADDRESS 9 Kimberly Court (21146) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 214.03.5188 | | 17. INFORMANT (Wife) ADDRESS Mrs. Jeanne E. Moore (same as #13) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <i>Coronary Artery due to Ventricular fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Myocardial Infarction and other</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Post Coronary Artery Bypass Graft</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>myocardial</i> | | | | | | | |
| 19a. DATE OF OPERATION 7-6-83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary artery disease with intractable angina | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Jose Presbitero, M.D.</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/12/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE PRESBITERO, M.D. | | | | 22e. ADDRESS 7845 OAKWOOD ROAD #205 GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 15, 83 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD | |
| 24. FUNERAL DIRECTOR NAME <i>H.B. Vinson</i> | | | | 25a. DATE REC'D. BY REGISTRAR DEC 15 1983 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i> | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|-----------------------------|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Edward Moreland | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 2 83 | | 2b. HOUR M 1645 |
| 3. SEX M | 4. RACE CAU | 5. DATE OF BIRTH MONTH DAY YEAR May 20, 1924 | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 59 YRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 2 83 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Galesville, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. |
| 10. CITY OR TOWN OF DEATH Galesville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4834 Muddy Creek Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer |
| 13a. STATE Md. | | 13b. COUNTY A.A. Co. | 13c. CITY OR TOWN Galesville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST C. Stallings Moreland | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Mae Woodfield | | 17. INFORMANT ADDRESS Moreland 4834 Muddy Creek Rd. Joan Giddings Galesville, Md |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 212-36-8964 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 Self Inflicted Gun Shot IMMEDIATE CAUSE (a) Wound of Head Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Wound of Head (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE William P. Jones, M.D. | | TITLE (SPECIFY) Deputy | | MEDICAL EXAMINER DATE SIGNED 2 Dec 83 |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | ADDRESS 695 America Ct Davidsonville 21035 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12/5/83 | 23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal | | 23d. LOCATION CITY OR TOWN COUNTY STATE West River, Md. |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | ADDRESS Ann. Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR DEC 5 1983 |

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25b. REGISTRAR'S SIGNATURE
John J. Smith

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U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

Charles E. Brown
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Wm. L. Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) TROY MORRISON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR DEC 8, 1983 | | | 2b. HOUR 6:15 PM | | | |
| 3. SEX MALE | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH DAY YEAR BEB 27 1917 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DODDRIDGE, ARK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | | |
| 10. CITY OR TOWN OF DEATH FT MEADE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KIMBROUGH ARMY COMMUNITY HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILITARY | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV. | | | |
| 13a. STATE MD | | | 13b. COUNTY A. A. | | 13c. CITY OR TOWN GLEN BURNIE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8098 MONTAGUE CT 21061 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Forrest Bloomer Morrison | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie = Carlisle | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. 1941-1961 435-05-0110 | | 17. INFORMANT Margaret B. Morrison | | | ADDRESS as Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 20 yr. 20 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Andrew Sanders, Gt, MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED Dec 8, 83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW SANDERS | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/12/83 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A. A. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | | | | ADDRESS Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 11 1983 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | | | | |

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Respiratory System
Chronic obstructive pulmonary disease
COPD
Asthma
Emphysema
Chronic bronchitis
Cystic fibrosis
Pneumonia
Tuberculosis
Lung cancer
Pleural effusion
Pneumothorax
Bronchiectasis
Idiopathic pulmonary fibrosis
Sarcoidosis
Hypersensitivity pneumonitis
Occupational lung disease
Radiation-induced lung disease
Drug-induced lung disease
Vasculitis
Connective tissue disease
Autoimmune disease
Infectious disease
Neoplasia
Trauma
Congenital disease
Genetic disease
Metabolic disease
Endocrine disease
Immunodeficiency
Hemorrhage
Thrombosis
Coagulopathy
Anemia
Polycythemia
Leukemia
Lymphoma
Myeloma
Solid tumor
Hematopoietic stem cell transplantation
Bone marrow transplantation
Organ transplantation
Cancer therapy
Immunotherapy
Gene therapy
Cell therapy
Tissue engineering
Regenerative medicine
Artificial organs
Prosthetics
Bionics
Nanotechnology
Biotechnology
Medicine
Healthcare
Pharmaceuticals
Medical devices
Surgical instruments
Diagnostic equipment
Therapeutic equipment
Medical research
Clinical trials
Medical education
Medical ethics
Medical law
Medical economics
Medical sociology
Medical anthropology
Medical history
Medical philosophy
Medical literature
Medical art
Medical music
Medical dance
Medical theater
Medical film
Medical television
Medical radio
Medical internet
Medical mobile devices
Medical wearable devices
Medical robotics
Medical artificial intelligence
Medical big data
Medical cloud computing
Medical blockchain
Medical cryptocurrency
Medical virtual reality
Medical augmented reality
Medical mixed reality
Medical haptics
Medical smell
Medical taste
Medical touch
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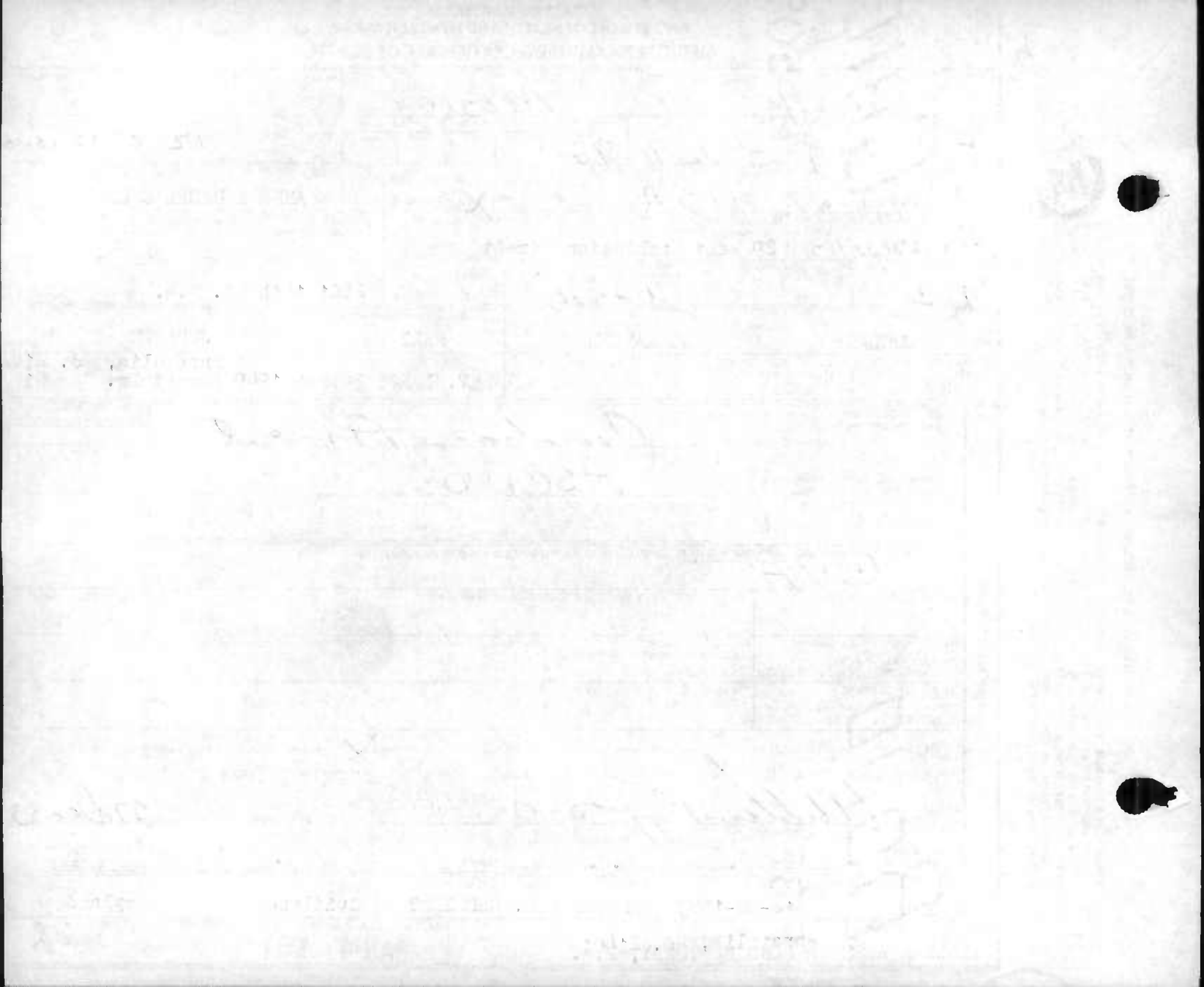
Dr. J. P. Anderson, M.D.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1E. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|-----------------------|--|--|---|--|--|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lucille Mosley | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 19 <input type="checkbox"/> | | 2b. HOUR M | | | |
| 3. SEX F | 4. RACE Neg | 5. DATE OF BIRTH MONTH DAY YEAR 5 6 91 92 | 6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN 92 | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 27 83 | | 2d. HOUR M 1302 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 29 West Washington Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE DC | | 13b. CITY OR TOWN WASH. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2801 14th St. N.W. 99999 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DOUGLAS ALEXANDER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY JOHNSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Annapolis, Md. 214 REV. LEROY BOWMAN 1949 Forest Dr. 01 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). C.V.A. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE William P. Jones | | | | TITLE (SPECIFY) Deputy | | MEDICAL EXAMINER | | DATE SIGNED 27 Dec 83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | | | ADDRESS 695 America Ct. Davidsonville 21035 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-30-1983 | | 23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83

31627

FOR
1 - STATE
REGISTRAR

REG. NO.

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|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph H. NAYLOR SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 30 1983 | | 2b. HOUR MIN. 10 P^M | |
| 3. SEX M | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 15 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 74 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 21401 | | |
| 13a. STATE MARYLAND | | 13b. COUNTY A.A. | 13c. CITY OR TOWN ANNAPOLIS | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK NAYLOR | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET CREEK | | 13e. STREET ADDRESS / ZIP CODE 300 Browns Wood Road | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-18-5488 | | 17. INFORMANT ADDRESS ANNIE NAYLOR 300 Browns Wood Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 4960 DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE LUNG DISEASE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/20/83 to 12/30/83 , that (I) (we) last saw the deceased alive on 12/20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Douglas C. Roane | | DEGREE M.D. | | 22c. DATE SIGNED 12/30/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas C. Roane, M.D. | | 22e. ADDRESS 1616 Forest Drive ANNAPOLIS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-5-1984 | | 23c. NAME OF CEMETERY OR CREMATORY HOPE CHURCH CEMETERY | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Edgewater A.A. Maryland | | 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | |
| 25a. DATE REC'D. BY REGISTRAR JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE John G. Connel | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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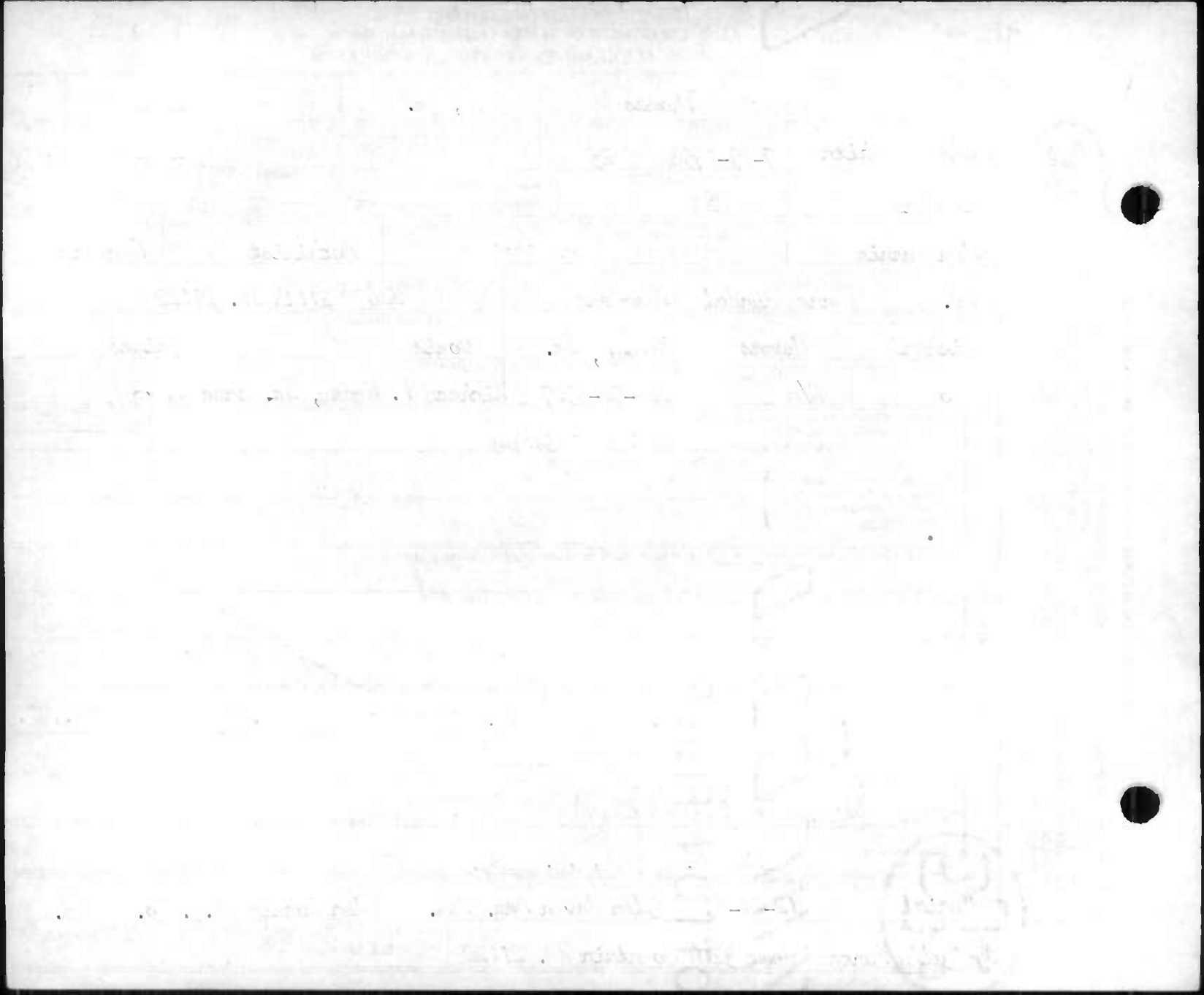
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WHEN FILING AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|---|--|--|--|----------|---|--|---|------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD Thomas NEARY, Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> MONTH DAY YEAR DEATH MATED <input type="checkbox"/> 12-18-83 | 2b. HOUR M 5:59A |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7-23-1958 | 6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-18-83 | 7d. HOUR | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY Factory | | | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | | 12c. STREET ADDRESS 670 211th St. 21122 | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Pasadena | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Thomas Neary, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Donis Grimes | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT Richard T. Neary, Sr. same as 13c | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto who struck a fixed object overturned and ejected | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rte. 100 & Jumpers Hole Rd. Anne Arundel Co., Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell, M.D. | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | DATE SIGNED 12-18-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12-21-83 | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Co. Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home | | | ADDRESS 3204 Mountain Rd. 21122 | | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | |



BP
DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| #1,14,15, FilmG586 1- FOR STATE REGISTRAR 12/14/83 kam | | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 83 31629 | | | | |
|---|--|---|--|---|--|--|--|--|---|--|--|--------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AUGUST JOHN NOWOTTNICK | | | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 3, 1983 | | | | | 2b. HOUR 8:46 AM | | | | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 10, 1908 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | | 7. UNDER 1 YEAR MONTHS DAYS | | 7. UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Keal Germany | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | | 12b. KIND OF BUSINESS OR INDUSTRY Fuel Oil | | | | |
| 13a. STATE Md. | | | | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Crownsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 710 Latham Dr. 21032 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST AUGUST John Nowottnick Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emelia H. Handke | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) NONE | | 17. INFORMANT ADDRESS Doris Saumenig 710 Latham Dr. Crownsville | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Marc A. Kaplan</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC A. KAPLAN, M.D. | | | | | | | | 22e. ADDRESS 7845 OAKWOOD RD. #200, GLEN BURNIE, MARYLAND 21061 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12/7/83 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis Md. A.A. | | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Annapolis Md. 21401 | | | | | | | | 25. DATE REC'D. BY REGISTRAR DEC 5 - 1983 | | 25b. REGISTRAR'S SIGNATURE <i>James G. Smith</i> | | | | |

THE UNIVERSITY OF CHICAGO

6350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

Nona Irene O'Connell

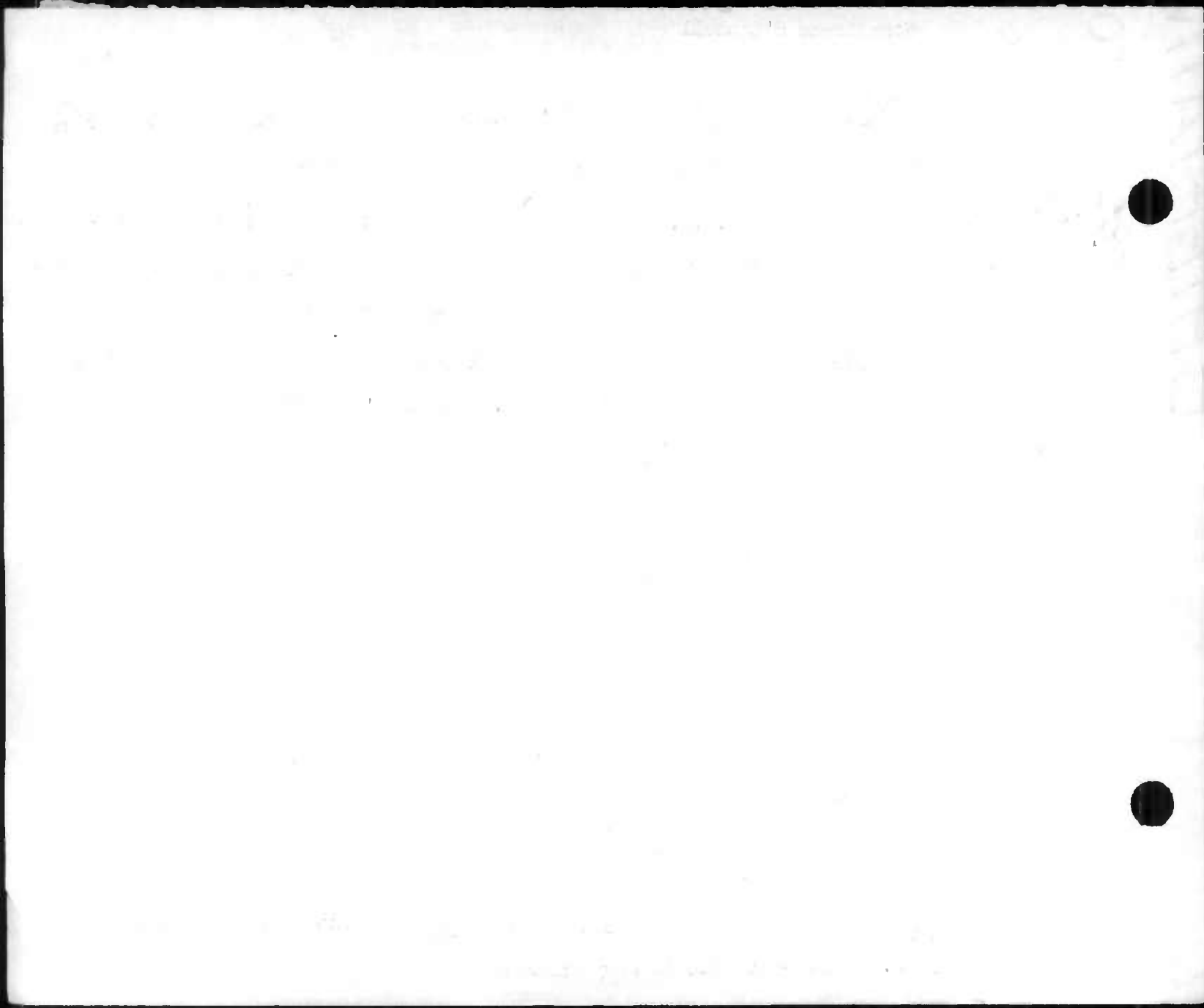
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31630

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nona Irene O'Connell | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 31 83 | | | 2b. HOUR 4 ⁰⁰ A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 03-06-18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY American Hammer & Piston | |
| 13a. STATE MARYLAND | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 154 East Bay View Drive 21403 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick Clements | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor England | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 214-14-8756 | | | 17. INFORMANT Mr. Michael O'Connell | | | ADDRESS Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Colon Cancer 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from 12/6/83, to 12/31/83, that (he) (we) last saw the deceased alive on 12/30/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.) | | | | | | | | | |
| 22b. SIGNATURE E. W. Cole III | | | | DEGREE MD | | | | 22c. DATE SIGNED 12/31/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III | | | | 22e. ADDRESS 57 FRANKLIN ANNAPOLIS MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/2/84 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION Catonsville Balto Md | | 23e. DATE RECEIVED BY REGISTRAR JAN 4 1984 | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | | | 25a. REGISTRAR'S SIGNATURE John J. Connel | | 25b. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21a, always any injury, or other traumatic event, the medical examiner must be notified in writing.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31631

| | | | | | |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) NELLIE M. PATANE | | December 12, 1983 | | P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. UNDER 1 YEAR | |
| Female | Caucasian | Nov. 2, 1891 | 92 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Sicily | USA | | Anne Arundel, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Annapolis | Annapolis Convalescent Center | | Homemaker | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | Anne Arundel | Crownsville | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 967 Sevard Lane 21032 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Rosario Muriabito | | Francesca Santangelo | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 579-10-5947B | | Mrs. Jack Stefanelli, (same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Consequence of unknown road</u> (c) <u>Consequence of unknown road</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Out</u> 19 <u>83</u> to <u>13 Dec</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>7 Dec</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | 22b. SIGNATURE <u>John B. Lowe</u> | | 22c. DATE SIGNED <u>15 Dec 83</u> | |
| 22d. PHYSICIAN NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| John B. Lowe | | 77 West St. Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Dec. 16, 1983 | | Fort Lincoln Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Brentwood, P.B. Maryland | | DEC 21 1983 | | John J. Conner | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 24b. ADDRESS | | | |
| Beall Funeral Home, Bowie, Maryland 20715 | | 16000 Annapolis Road | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 6 3 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruth S. Paulus Paulus | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-20-83 | | | | 2b. HOUR 6:25 PM | | | |
| SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 4-4-23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Keller Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) store owner | | 12b. KIND OF BUSINESS OR INDUSTRY grocery | | | |
| 13a. STATE Md. | | | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Shady Side | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4801 Avery Rd. 20764 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Sturgis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Dunton | | | | 16. ADDRESS 4801 Avery Rd. Shady Side, Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 215-12-4963 | | 17. INFORMANT Wm Jacob Paulus | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Breast Cancer a long metastasis 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19____, to 12/20/83 , 19____, that (I) (we) last saw the deceased alive on 12/19/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE S. P. Watkins | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. P. WATKINS | | | | 22e. ADDRESS ENSEN COLE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/22/83 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, Md. A.A. Co. | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | | | ADDRESS 12 Ridgely Ave Ann. Md. 21401 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

BP



CHATELAIN

200-0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Quenna A. Pearson | | 2a. DATE OF DEATH MONTH DAY YEAR Dec 19 1983 | | 2b. HOUR 0945a M |
| 3. SEX Male | 4. RACE CAU White | 5. DATE OF BIRTH MONTH DAY YEAR May 29, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 82 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. |
| 10. CITY OR TOWN OF DEATH Ft. Meade, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Comm. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. ARMY | 12b. KIND OF BUSINESS OR INDUSTRY Retired |
| 13a. STATE MARYLAND | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Charles Pearson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mittie Lenora Jackson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WW 11 21836 25 15 | | 17. INFORMANT ADDRESS Lucille Pearson same as 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Peripheral Vascular Disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 15 Years 10 Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Bronchitis - Gastrointestinal Bleed | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 13 Dec , 19 83 , to 19 Dec , 19 83 , that (I) (we) last saw the deceased alive on 19 Dec 83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Gwenesta B. Melton | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 19 Dec 83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gwenesta B. Melton, Cpt, M.C. | | 22e. ADDRESS Kimbrough Army Community Hospital, Ft. Meade | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 21 Dec. 83 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk. | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley | | ADDRESS Glen Burnie MD. | | 25a. DATE REC'D. BY REGISTRAR DEC 20 1983 |
| | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

1. Name: ANN ARTHUR GILSON
 2. Date of Birth: 1925 05 15
 3. Sex: M
 4. Race: W
 5. Height: 5' 10"
 6. Weight: 175
 7. Blood Type: A
 8. Social Security Number: 21-788-45678
 9. Address: 1234 Main St, Springfield, MA 01101
 10. Telephone: 555-1234
 11. Occupation: Engineer
 12. Education: High School Graduate
 13. Marital Status: Single
 14. Number of Children: 0
 15. Current Residence: 1234 Main St, Springfield, MA 01101
 16. Previous Residence: None
 17. Date of Entry: 1950 01 01
 18. Date of Exit: 1950 01 01
 19. Reason for Entry: Immigration
 20. Reason for Exit: Departure
 21. Status: Active
 22. Remarks: None

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE MAE PERSINGER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 03, 1983 | | 2b. HOUR PM 200 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 23 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Millersville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 210 Michelle Circle 21108 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Brown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Paul | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO. 307-07-8648 | | 17. INFORMANT ADDRESS Mrs. William Wallace 719 Cottonwood Drive Severna Park, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Encephalopathy</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u> 2 days DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> 1 year APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12-1 19-3 12-3 19-3 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-1</u> 19 <u>83</u> to <u>12-3</u> 19 <u>83</u> that (I) (we) lost saw the deceased alive on <u>12-3</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE (OF PHYSICIAN) NAME (TYPE OR PRINT) HILARY T. O'HERLITHY | | DEGREE | | 22c. DATE SIGNED 12-3-83 | | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. ADDRESS 325 HOSPITAL DRIVE SUITE 208 GLEN BURNIE, MARYLAND 21061 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-7-83 | | 23c. NAME OF CEMETERY OR CREMATORY Beech Grove Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Muncie Delaware Indiana | | | |
| 24. FUNERAL DIRECTOR NAME Marzullo Funeral Service | | | | ADDRESS Reisterstown, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 5 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

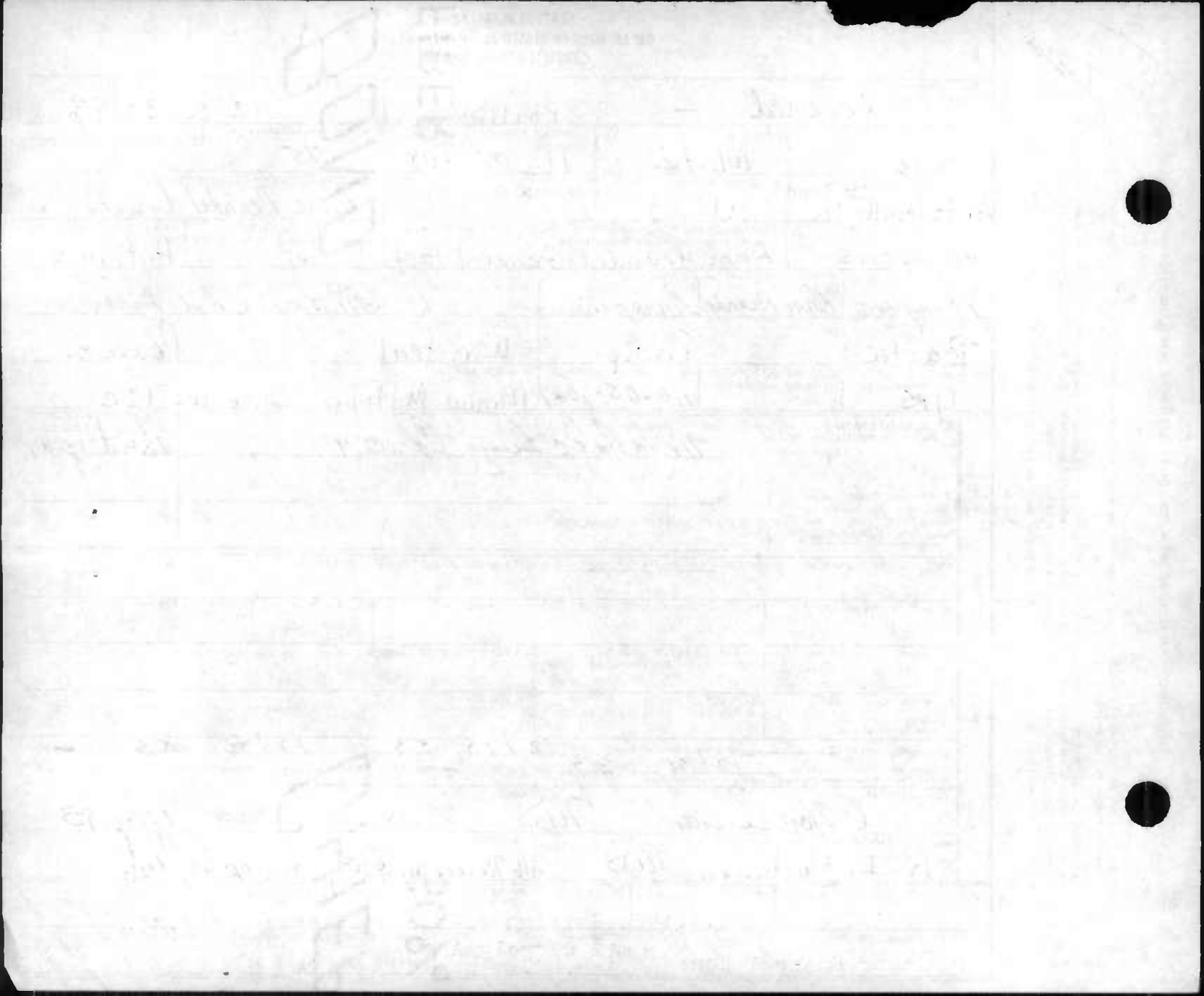
| | | | | | | | |
|--|--|---|--|---|-------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEONARD - Philip | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 30 83 | | 2b. HOUR 9⁴⁵ M | | |
| 3. SEX male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 05 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp | | 12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE) Dealer | | 12b. KIND OF BUSINESS OR INDUSTRY Antiques | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Annapolis | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 311 Taylor Ave, Annapolis 21401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Baxter Philip | | 15. MOTHER'S MARRIED NAME FIRST MIDDLE LAST Winifred Pearce | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 110-05-6327 | | 17. INFORMANT ADDRESS Minna M. Philip same as 13e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung Cancer 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 1 year | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/28 1983 to 12/30 1983 , that (I) saw the deceased alive on 12/30 1983 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R. I. Hochman, MD | | | | DEGREE MD | | 22c. DATE SIGNED 12/31/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. I. Hochman, MD | | | | 22e. ADDRESS 16 Murray Ave, Annapolis, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 4, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew Cemetery Balt. Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | ADDRESS 2 Ridgely Ave Ann. Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE John J. Chief | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8331636

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) William A. Pokorny | | | 2a. DATE OF DEATH MONTH DAY YEAR December 10, 1983 | | 2b. HOUR 8¹⁵ P. | |
| 3. SEX male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR January 24 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Annapolis | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 332 Epping Way 21401 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST late Alois Pokorney | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Hermine Klauffuss | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW 11 | | 16b. SOCIAL SECURITY NO. 215 09 5751 | | 17. INFORMANT ADDRESS Mrs Margaret Pokorny 332 Epping Way 21401 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2000 IMMEDIATE CAUSE (a) Nischaotic lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/16 19 83 to 12/10 19 83 , that (I) (we) last saw the deceased alive on 12/10 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE R Beem / for S. P. LUTIKINS DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/10/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Biern | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 14, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Co., Md/ |
| 24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia Rd Ellicott City | | | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1983 | | 25b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Harry H. Wicks, 1112 Columbia Blvd, Ellicott City

Dec 14, 1983 Maryland Veterans Cemetery
Crownsville A.A. Co., Md

Yes
NW 11
213 00 2751
Mrs. Margaret Pokorney 332 Epping Way 21401

Late Alois Pokorney
Maryland Anne Arundel Annapolis
Late Gerline Kinsler

332 Epping Way 21401

Retired

Baltimore Md. U.S.A.

x

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | | | |
|---|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST ADA VERA PORTER | | | MONTH DAY YEAR DECEMBER 30, 1983 | | | EST 9:30A M | | | |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 9 24 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 59 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR WHICH OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND | | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN SEVERN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BROWN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA A. HILTON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS BILLIE WOODS 3050 Southland Rd. Balto., Md. 21225 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 4/69 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec. 29, 1983 , to Dec. 30, 1983 , that (1) (we) lost saw the deceased alive on Dec. 30, 1983 , and that in my (my) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Charles J. Wu | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED Dec. 30, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU, M.D. | | | 22e. ADDRESS 7845 OAKWOOD ROAD, #204 GLEN BURNIE, MARYLAND 21061 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-5-1984 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Church Ceme. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arnold A.A. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE John J. Carick | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.



GREENING

Submitted by _____ Date _____
Approved by _____ Date _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | WILLIAM ERNEST PRIEBE SR | | DECEMBER 13, 1983 | | 0620 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | March 2, 1924 | | 59 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | USA | | | | ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Sheet Metal | | Westinghouse | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | | | AA | | Glen Burnie | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Frederick Priebe | | | | Louise Lotz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| Yes | | WW II | | 218-18-5745 William E. Priebe, Jr., Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u> 4920 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive pneumothorax</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Bullous emphysema</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Aneurysm - Cerebral - melanosis.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/12/83</u> to <u>12/13/83</u> , that (I) (we) lost saw the deceased alive on <u>12/12/83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Nick Moutsos</u> | | MD | | | | 12/13/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| NICK MOUTSOS, M.D. | | 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 16 Dec 83 | | Meadowridge Mem. Park | | Elkridge Howard MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| James S. Kirkley, Glen Burnie, MD | | | | DEC 15 1983 | | <u>John J. [Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Division of Vital Records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

WEST VIRGINIA HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADIE JEAN PUNCOCHAR | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1983 | | 2b. HOUR 10:15 M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1909 | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Millersville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 21108 8183 Weyburn Road |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kochanowski | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Novack | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217.09.6727 | | 17. INFORMANT Daughter ADDRESS Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory insufficiency 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction (c) Pulmonary Embolism | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Esophageal tear with chronic pleuritis, adhesions & small abscess. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Frank A. Faraino, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 12/28/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK A. FARAINO, M.D. | | 22e. ADDRESS 1205 YORK ROAD, SUITE 38 LUTHERVILLE, MARYLAND 21093 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Dec. 29, 83 | 23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home, Glen Burnie, MD | | | 25. DATE REC'D. BY REGISTRAR DEC 30 1983 | | |

11/11/11

11/11/11

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 3500

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rachel Merle Pyle | | 2a. DATE OF DEATH MONTH DAY YEAR Dec. 17, 1983 | | 2b. HOUR 1:30 P.M. | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 11-22-1896 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Shady side, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1766 Dunton Rd. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | |
| 13a. STATE Md. | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Annapolis | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Murray | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Leatherbury | | 16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16c. SOCIAL SECURITY NO. 215-38-3664 | | 17. INFORMANT ADDRESS 825 Holly Dr. E. Mrs Wm. H. Russell Ann. Md. 21401 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular disease</u> 4379 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-28-1981</u> , 19 <u>82</u> , to _____, 19____, that (I) (we) lost saw the deceased alive on <u>2-7-83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>G. A. Mitchell</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12-19-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Mitchell | | 22e. ADDRESS 205 Ridgely Ave Annapolis Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/20/83 | | 23c. NAME OF CEMETERY OR CREMATORY Woodfield Cemetery Galesville, Md. A.A. Co. | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connelley</u> | |

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U.S. DEPT. OF AGRICULTURE



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) TILGHMAN D. Rawlings | | | 2a. DATE OF DEATH MONTH 12 DAY 12 YEAR 83 | | 2b. HOUR P_M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH 9 DAY 22 YEAR 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNAPOLIS MD. | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 129 BAY SHORE AVE | | 12a. USUAL OCCUPATION (TYPE WORK FOR NON-PROFESSIONAL LIFE) YACHT YARD | 12b. KIND OF BUSINESS OR PROFESSION PIPERIA | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY AA 13c. CITY OR TOWN ANNAPOLIS | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 129 BAY SHORE AVE 21403 | |
| 14. FATHER'S NAME FIRST TILGHMAN MIDDLE SCHE LAST RAWLINGS | | | 15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE REDMOLD LAST REDMOLD | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 212182512 | 17. INFORMANT NAME RUTH H. RAWLINGS ADDRESS #13 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

1541 IMMEDIATE CAUSE (a) Cerebral Reticulum
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

| | | |
|--|--|--------------------------------------|
| 22b. SIGNATURE <i>[Signature]</i> | DEGREE | 22c. DATE SIGNED Dec 13 83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen B. Hiltabidle MD | 22e. ADDRESS 801 Melvin Ave, Annapolis, MD | |

| | | | |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12/15/83 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff | 23d. LOCATION CITY OR TOWN ANNAPOLIS COUNTY AA STATE MD |
| 24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL ADDRESS ANNAPOLIS MD | | 25. DATE RECEIVED BY FUNERAL HOME DEC 15 1983 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. In the second part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

3. The third part of the paper is devoted to a discussion of the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

4. In the fourth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

5. The fifth part of the paper is devoted to a discussion of the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

6. In the sixth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

7. The seventh part of the paper is devoted to a discussion of the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

8. In the eighth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

9. The ninth part of the paper is devoted to a discussion of the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

10. In the tenth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERMA M REINHART | | | 2a DATE OF DEATH MONTH DAY YEAR Dec. 2 83 | | 2b HOUR M |
| 3 SEX FEMALE | 4 RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR Dec 14 1914 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 | 7 UNDER 1 YEAR MONTHS DAYS YRS. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10 CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES PERSON | 12b KIND OF BUSINESS OR INDUSTRY BALD. 6+E | |
| 13a STATE MARYLAND | | | 13b COUNTY Anne Arundel | 13c CITY OR TOWN Crownsville | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST CHARLES METZGER | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA DRESSSEL | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 215-01-4395 | | 17 INFORMANT ADDRESS GEORGE REINHART (SAME AS 13E) | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) endometrial stromal sarcoma 1820 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) this hospital attended the deceased from Sept 8 1983 to 12/2 1983 , that (I) have) lost saw the deceased alive on 12/2 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) we (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Joseph D. Moser | | DEGREE MD | | 22c DATE SIGNED 12/2/83 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph D Moser | | 22e ADDRESS | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 12-6-83 | | 23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | |
| 23d LOCATION CITY OR TOWN COUNTY STATE BROOKLYN A.A. MD. | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE DEC 5 1983 | | | |
| 24. FUNERAL DIRECTOR NAME GEORGE J. GONCE F.H. | | ADDRESS 4001 RITCHIE HWY. | | 25. DATE REC'D. BY REGISTRAR 25f. REGISTRAR'S SIGNATURE DEC 5 1983 | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

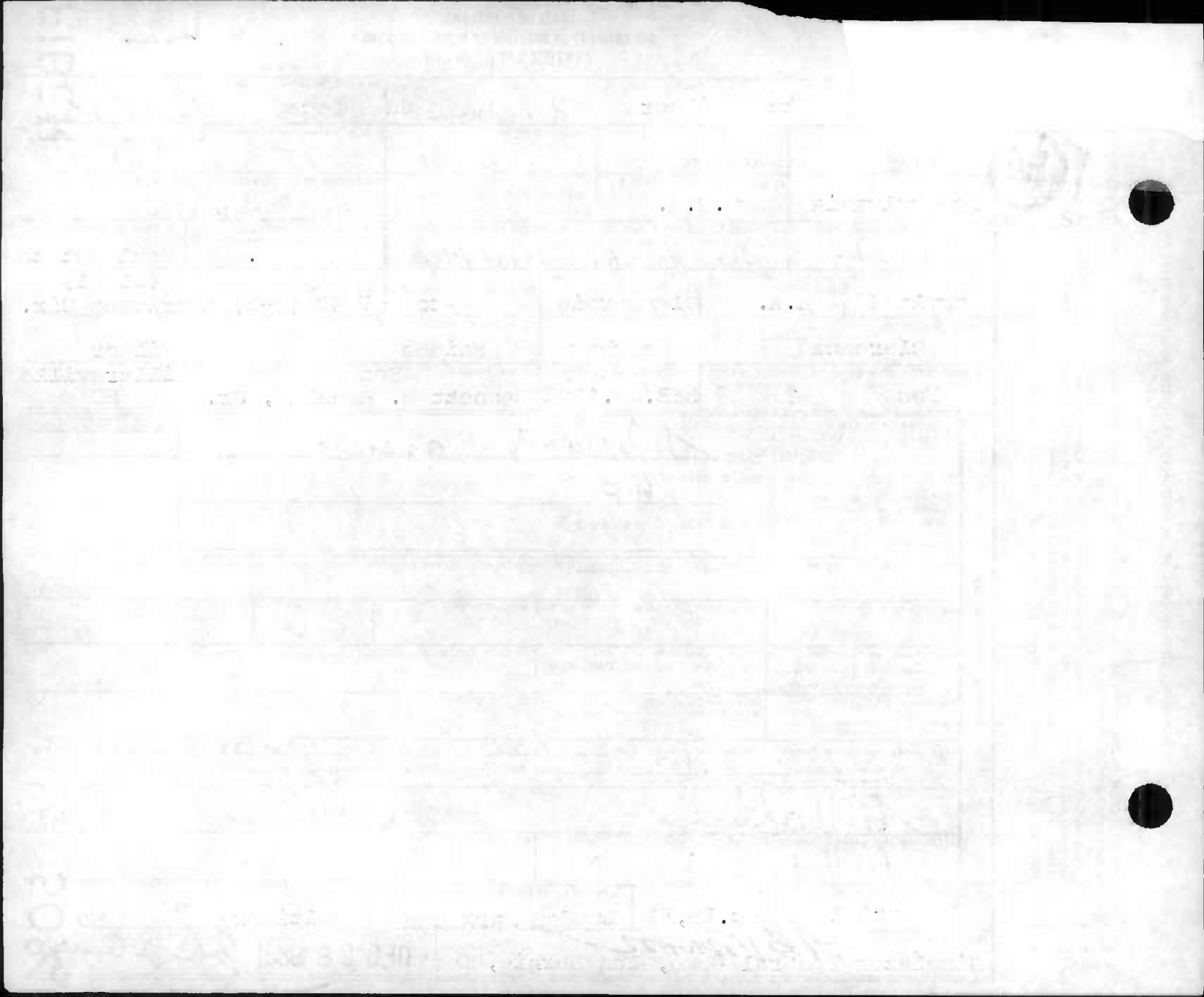
REG. NO.

| | | | | | | |
|--|--|--|---|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Bennett Milnor Renshaw SR | | | 2a. DATE OF DEATH MONTH DAY YEAR December 26-83 | | 2b. HOUR 149 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 31-08 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 12. CITY OR TOWN OF DEATH Annapolis | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Emp. | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland | | 15b. COUNTY A.A. | | 15c. CITY OR TOWN Glen Burnie | | |
| 16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 17. STREET ADDRESS / ZIP CODE (21061) 7542 (T-2) Americana Cir. | | 18. KIND OF BUSINESS OR INDUSTRY Real Estate | | |
| 19. FATHER'S NAME FIRST MIDDLE LAST Clarence Renshaw | | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maidee Milnor | | 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes ? | | |
| 22. SOCIAL SECURITY NO. 363.09.1292 | | 23. INFORMANT Son Bennett M. Renshaw, Jr. | | 24. ADDRESS Millersville MD | | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden cardiac anemia</u> 2850 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 26. DATE OF OPERATION | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 35. LOCATION STREET CITY OR TOWN COUNTY STATE | | 36. I certify that (I) (this hospital) attended the deceased from <u>1978</u> , 19____, to <u>12/26/83</u> , 19____, that (I) (we) last saw the deceased alive on <u>12/25/83</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 37. SIGNATURE <u>S. P. Watkins</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 38. DATE SIGNED 12/26/83 | | 39. PHYSICIAN'S NAME (TYPE OR PRINT) S. P. WATKINS | | 40. ADDRESS | | |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 42. DATE Dec, 29, 83 | | 43. NAME OF CEMETERY OR CREMATORY Loudon Park Cem | | |
| 44. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | 45. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD | | 46. DATE REC'D. BY REGISTRAR DEC 28 1983 | | |
| 47. REGISTRAR'S SIGNATURE <u>John J. Lewis</u> | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME

FIRST MIDDLE LAST
Page N. Riddleberger

2a. DATE OF DEATH

MONTH DAY YEAR
12 3 83

2b. HOUR
805 a
M

3. SEX

male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
Sept. 11, 1907

6. AGE (IN YEARS (LAST BIRTHDAY))

76

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS

HOURS MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

VA

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel Co. MD.

10. CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Anne Arundel Gen Hosp.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE) Retired

12b. KIND OF BUSINESS OR

INDUSTRY Civil Service

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

AA

13c. CITY OR TOWN

Annapolis

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

102 Roselawn Rd 21403

14. FATHER'S NAME

FIRST MIDDLE LAST
Linwood Riddleberger

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Mary Windle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

213-14-1076

17. INFORMANT

Joan R. Perry -

ADDRESS

204 F. Victor Parkway Annapolis, MD 21403

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4140

IMMEDIATE CAUSE (a)

Chronic congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

Ischemic Cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF

(c)

Coronary Atherosclerotic heart disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Renal failure

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I, this hospital) attended the deceased from

11/20/83

19

83

to

12/13/83

19

83

that (I, we) lost

saw the deceased alive on above (I, we) (did) (did not) view the body after death.

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/15/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

George P. Samaras

22e. ADDRESS

205 Ridgely Ave. Ann. MD 21401

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)

Burial

23b. DATE

Dec 6 1983

23c. NAME OF CEMETERY OR CREMATORY

Hillcrest

23d. LOCATION CITY OR TOWN

Annapolis

COUNTY

AA

STATE

MD

24. FUNERAL DIRECTOR

Taylor Funeral Chapel - Annapolis, MD

25. DATE RECD BY REGISTRAR

DEC 7 1983

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELISE H. RIDOUT | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 23, 1983 | | | 2b. HOUR 12:35 P ^M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12. USUAL OCCUPATION (IF WORK FOR MORE THAN ONE, GIVE WORKING #) School Teacher Public Schools | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MD. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1611 St. Margaret's Rd. 21401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ZACHARIAH RIDOUT | | | | 15. MOTHER'S MARRIED NAME MIDDLE LAST ETLEN MEZICK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS Wallace Babbitt #13 21401 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4850 DUE TO, OR AS A CONSEQUENCE OF (b) <u>possible septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pneumonia or urinary tract infection</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>AS HD; Possible CVA.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION <u>N/A</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u> 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 10</u> 19 <u>83</u> , to <u>Dec. 23</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 23</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Benjamin A. de Guzman, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>12/23/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN A. de GUZMAN, M.D. | | | | 22e. ADDRESS 325 HOSPITAL DRIVE #108 GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | 23b. DATE <u>12/24/83</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery, Suitland, P.G. MD.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME <u>Taylor Funeral Chapel, Annapolis, MD.</u> | | | | 24b. ADDRESS | | 25. DATE REC'D. BY REGISTRAR <u>DEC 29 1983</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> | |

BP

1866

RECEIVED
JAN 12 1866

1866

1866

DEC 2 1865

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BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William A Rinehart Sr. | | 2a. DATE OF DEATH MONTH DAY YEAR 12-21-83 | | 2b. HOUR 6:15 A.M. | |
| 3. SEX m | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 3-25-99 | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp | | 12a. USUAL OCCUPATION (IF PLAYS FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. STATE Md. | | 13b. COUNTY A.A. Co. | 13c. CITY OR TOWN Lothian | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 340 Bayard Rd 20711 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Rinehart | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Culbertson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-12-4232 | 17. INFORMANT 4852 S Polling House Rd, Harwood Md William A. Rinehart Jr. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Gastrointestinal Bleeding 2030 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) Multiple Myeloma, COPD | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12/1 83 12/21 83 | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/19 83, and that (2) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE E W COLE III | | DEGREE MD | | 22c. DATE SIGNED 12/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III | | 22e. ADDRESS 51 FRANKLIN ST ANNAP. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 12-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Zion UM Church | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Lothian A.A. Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS T.A. Hardesty Annapolis Md. 21401 | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conish | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|--|---|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian J. Schmidt | | | 2a. DATE OF DEATH MONTH DAY YEAR Dec 22, 1983 | | 2b. HOUR MIN 12:15 A | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 25, 1891 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | 8. CITIZEN OF WHAT COUNTRY? USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Annapolis - Anne Arundel MD. | | 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bay Manor Convalescent Center | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS 1006 Edgerly Road 21061 | | |
| 13a. STATE Maryland | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Montgomery Johnson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Marks | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | |
| 16b. SOCIAL SECURITY NO. 219-16-8095 | | 17. INFORMANT Betty S. Litz, Same as 13 | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAL ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: STATUS POST PACE MAKER INSERTION | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <i>George Kurian</i> | | DEGREE MD | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE KURIAN | | 22e. ADDRESS 14, WELHAM AVE, SUITE 101, GLENBURNIE, MD. 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 24 Dec 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore MD | | 24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD | | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 23 1983 | | 25b. REGISTRAR'S SIGNATURE <i>Sam J. Smith</i> | | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WESLEY W. SEWELL | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/6/83 | | | 2b. HOUR MIN. 7:35 A M | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2 22 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 75 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CUBA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH CROWNSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFIELD NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROFESSOR | | 12b. KIND OF BUSINESS OR INDUSTRY LANGUAGES | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY AA | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2017 ELMWOOD RD. 21401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. SEWELL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LULA SMITH | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-46 | | 17. INFORMANT JOSEPHINE G. SEWELL | | ADDRESS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest 4148 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Constrictive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic Cardiomyopathy | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Jan 1, 19 83, to Dec 6, 19 83, that (1) (we) lost saw the deceased alive on Nov. 22, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE BARRY R. NATHANSON | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE, SIGNED 12/6/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON | | 22e. ADDRESS 51 Franklin St. Annapolis, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 12/7/83 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | 23d. LOCATION CITY OR TOWN COUNTY STATE SMITHAND P.G. M.D. | | | |
| 24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL | | ADDRESS ANNAPOLIS MD | | 25a. DATE REC'D. BY REGISTRAR DEC 8 1983 | | | | | |
| 25b. REGISTRAR'S SIGNATURE John J. Carish | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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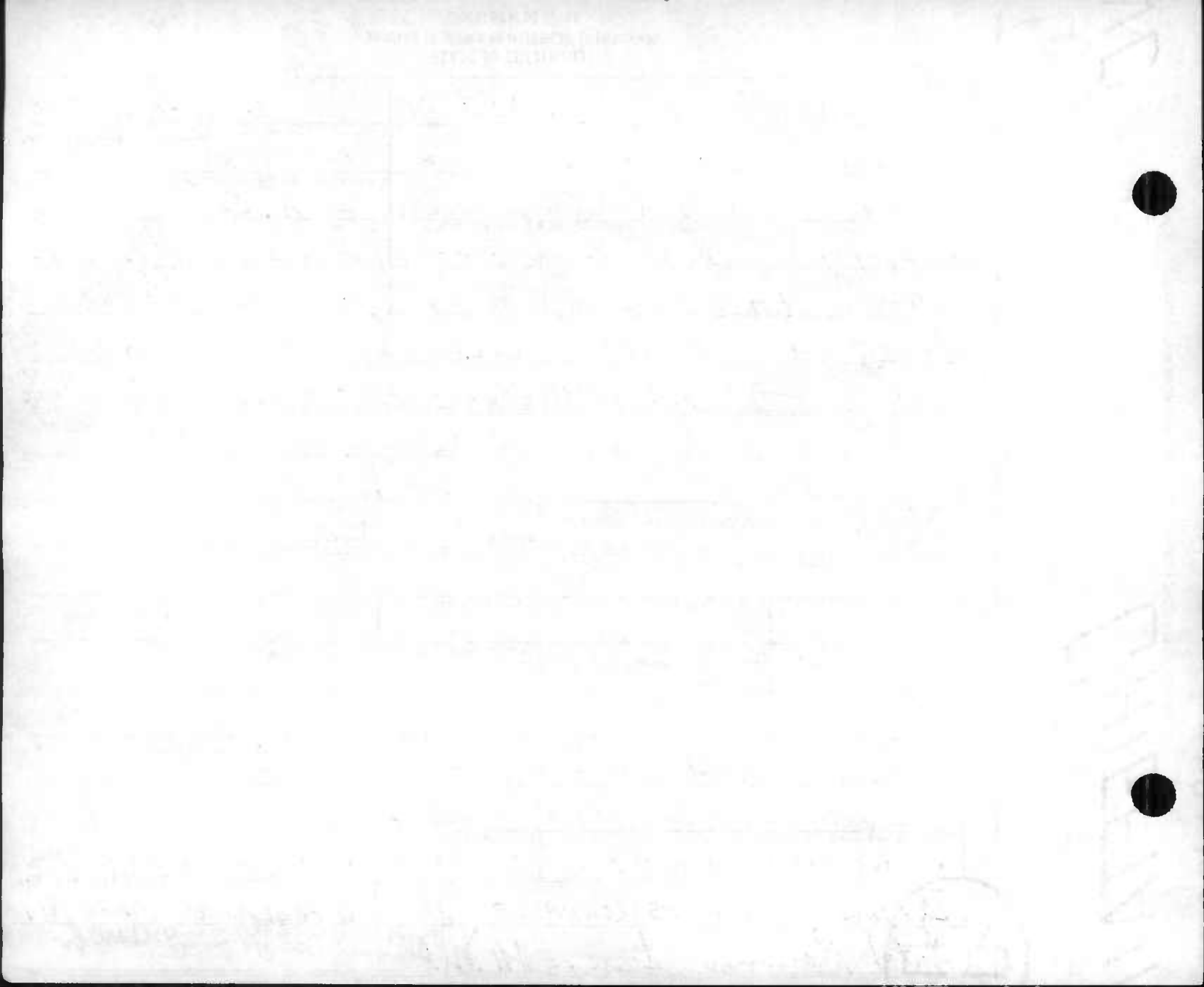
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

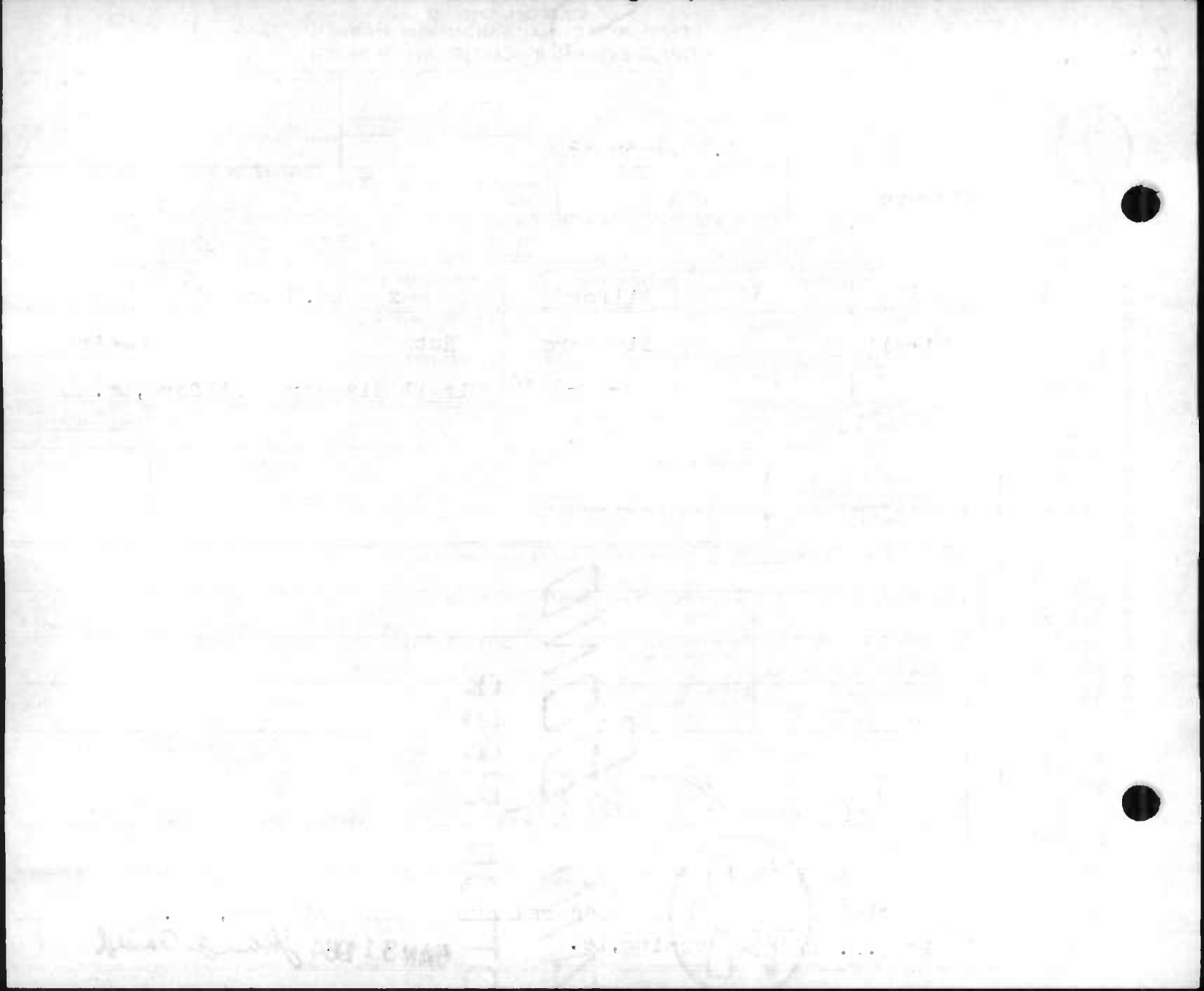
| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MERLE W SHOCKEY, SR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-19-83 | | | | 2b. HOUR 12:25 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2-24-02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A. A. Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A. A. GEN. Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY SPICE CO. | |
| 13a. STATE MD. | | 13b. COUNTY A. A. Co. | | 13c. CITY OR TOWN SEVERNA PK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 677 HOLLYWOOD RD. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES A. SHOCKEY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN ELIZABETH SIMSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215056861 | | 17. INFORMANT ADDRESS EDWARD F. SHOCKEY - SEVERNA PK 21146 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic heart disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Years. Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6 , 19 83 , to 12/19 , 19 83 , that (I) last last saw the deceased alive on 12/14/83 , 19 83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was not did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Gerard Blum | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 12/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD BLUM | | | | 22e. ADDRESS 8 EVERETT RD AN SEVERNA PARK MD 21146 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-21-83 | | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE PK | | 23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTO MD | | | |
| 24. FUNERAL DIRECTOR NAME Robert Bananas | | | | ADDRESS Severna Park, Md. | | | | 25a. DATE REC'D. BY REGISTRAR/SE REGISTRAR'S SIGNATURE DEC 27 1983 | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|---------------------|---|---|---|------------------|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Daniel C. Sizemore | | | | | | 2a. DATE KNOWN OF DEATH EST. MATED XX 12-3 19 83 | | 2b. HOUR M | | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1951 | 6. AGE (IN YEARS) LAST BIRTH YRS. 32 | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-24 1984 | | 2d. HOUR 6:00 P. M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD | | | | | |
| 10. CITY OR TOWN OF DEATH Severna Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Severna Pk. Mall - parking lot in auto | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D&Dold & New Ship | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STREET ADDRESS Rd. 3 Box 438 9999 | | | | | |
| 13a. STATE Del. | | 13b. COUNTY K | | 13c. CITY OR TOWN Milford | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Virgil Sizemore | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Ware Weir | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 222-36-3056 | | 17. INFORMANT ADDRESS Virgil Sizemore Milford, De. RD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot Wound of Head (unspecified) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR est. ? P.M. 12-3 19 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject was shot | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) found in auto | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Severna Pk. Mall, Severna Pk., Anne Arundel Co., | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Md. death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 1-26-84 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE ✓ | | 23c. NAME OF CEMETERY OR CREMATORY Odd Fellows | | 23d. LOCATION CITY OR TOWN COUNTY STATE Milford, Del. | | | |
| 24. FUNERAL DIRECTOR NAME Pippin F.H. CL167 Wyoming, De. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 31 1984 | | 25b. REGISTRAR'S SIGNATURE John J. Casper | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP

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20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|-----------------------------|--|---|--|---|--|--|--|---|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 31651 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph William Smiddy | | | | | | | | | | 2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 12-20 1983 | | 2b. HOUR M 7:22 p.m. | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 9-14-1981 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 2 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD 12-20 1983 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD. | | | |
| 10. CITY OR TOWN OF DEATH Ft. Meade | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) - | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Severn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1919 Huguenot Pl. (21144) | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Earl Smiddy | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julie - Fradel | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS Wilmington, Del. Earl Smiddy 1907 Oldwood Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 9138 Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 7:00 p.m. 12-20 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject became entangled in drapery cord | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1919 Huguenot Pl., Severn, Anne Arundel Co., Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 12-21-83 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12-22-83 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Erin Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Havre De Grace (Harford) Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Raymond C. Fink Glen Burnie, Md. | | | | | | | | | | | | | |
| 25a. DATE REC'D BY REGISTRAR DEC 27 1983 | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | | | | | | | | | |

RECEIVED
FEB 10 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

[Illegible body text]

RECEIVED
FEB 10 1964

ADMINISTRATIVE PAGE
[Illegible footer text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles A Smith | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-24-83 | | 2b. HOUR 10⁵⁰ P. M. |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 2-2-96 | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service - | | 12b. KIND OF BUSINESS OR INDUSTRY WGL Co. |
| USUAL RESIDENCE 1 IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION | | 13a. STATE Md. | 13b. COUNTY HT | 13c. CITY OR TOWN Lothian | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Smith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Gibbson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. W.W.I 578-09-1404 | | 17. INFORMANT ADDRESS Ruth V. Smith, Wife, Same as Above | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive cardiac resp. failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week |
| 7331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Fractured Left hip | | 1 week |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) COPD, ASCKA = CHF, Organic brain syndrome | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 12/16/83 to 12/24/83 , that (I) (we) last saw the deceased alive on 12/24/83 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Jon Lowe | | DEGREE M.D. | 22c. DATE SIGNED 12/25/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon Lowe, M.D. | | 22e. ADDRESS Anne Arundel Hospital, Ann., Maryland | |

| | | | |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12-29-83 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS Robt E Wilhelm 4308 Suitland Rd., Suitland, Md. | | 25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE JAN 03 1984 John J. [Signature] | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward A. Smith | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-28-83 | | 2b. HOUR 12:40 M. | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 6-21-02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Ann Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ann Arundel General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist | |
| 12b. KIND OF BUSINESS OR INDUSTRY Paint Co. | | 13a. STATE Md. | | 13b. COUNTY Q.A. | | 13c. CITY OR TOWN Chester | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew J. Smith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Walgate | | 16. STREET ADDRESS / ZIP CODE Skipper Lane 21619 | | | |
| 17. INFORMANT Phyllis Wright | | ADDRESS Chester Md. 21619 | | | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 160-09-5578 | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOTENSION & SEPSIS 2050 DUE TO, OR AS A CONSEQUENCE OF (b) ANEMIA, THROMBOCYTOPENIA & LEUKOCYTOSIS 12 MOS DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYELOMONOCYTIC LEUKEMIA 1 YR | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16 19 83 , to 12/28 83 , that (I) (we) last saw the deceased alive on 12/27 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dr. E. Bouleau | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/28/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-31-83 | | 23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Guilford N.C. | |
| 24. FUNERAL DIRECTOR NAME Gordon E. Bouleau | | | | ADDRESS Greensboro, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Canine | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6 50M 4/83
(5, 4)

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) OPAL A. SMITH | | | 20. DATE OF DEATH MONTH DAY YEAR December 4, 1983 | | 2b. HOUR 8:03p M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Jan. 31st, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY South Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | | 13c. CITY OR TOWN Annapolis | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Burton Ingram | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Pittigrew | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 235 44 2381 | 17. INFORMANT 7734 Washington Bl'vd #68 Alice M. Johnson Baltimore, Md. 21227 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 2765 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) HYPOVOLUMEA AND SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE GASTROINTESTINAL BLEEDING | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PAGET'S DISEASE, HYPOTHYROIDISM, OLD CEREBROVASCULAR ACCIDENTS | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-29-1983 to 11-29-1983 , that (I) (we) lost saw the deceased alive on 11-29-1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>George Kurian</i> | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Dec. 6, 1983 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Kurian, M.D. | | | 22e. ADDRESS 14 Wellham Ave. Glen Burnie, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | 23b. DATE 12/8/83 | 23c. NAME OF CEMETERY OR CREMATORY St. John's Church Cem | 23d. LOCATION CITY OR TOWN COUNTY STATE Beltsville P.G. Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | 25. DATE REC'D. BY REGISTRAR DEC 8 1983 | | |

REGISTRAR'S SIGNATURE
John J. Cane

Francis Jacobs, 1000 Mineral Road, ...
 12/18/82
 21. John Church Co. Baltimore, Md.
 10 William Ave. Glen Burnie, Maryland

Dec. 6, 1982

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|----------------|---|---------------|----|-------------------------|
| Female | White | Jan. 21, 1908 | 75 | |
| South Carolina | W. S. A. | x | | Anne Arnold |
| Annapolis | Anne Arnold General Hospital | | | |
| Maryland | Anne Arnold | x | | 500 Revell Highway |
| Illinois | Illinois | | | Littleton |
| 70 | 275 14 2521 Alice M. Johnson Baltimore, Md. 21207 | | | 774 Washington Blvd. W. |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31655

1. FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) DAISY E. SOCKRITER | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 6, 1983 | | | 2b. HOUR 10:19^{AM} | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 15, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 75 | | 7. IF UNDER 1 YEAR MONTHS DAYS 75 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 13a. STATE Maryland | | 13b. COUNTY ----- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3710 Ninth St., 21225 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | |
| 16a. SOCIAL SECURITY NO. 222-09-1002 | | 17. INFORMANT William H. Sockriter | | | | ADDRESS Glen Burnie, Md. 21061 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1534 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Shock DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction with atherosclerotic coronary artery disease | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic. Ischemic. D.C. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1976 , 19____, to Present , 19____, that (I) (we) last saw the deceased alive on 12/5/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Nick Moutsos | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/6/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NICK MOUTSOS, M.D. | | | | 22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/9/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Ph. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Homes Balto., Md., 21225 | | | | 25. DATE RECEIVED BY REGISTRAR DEC 9 1983 | | | | | |
| 25. REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use at the burial or cremation. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.)

3.2.2. SECTION 3.1.1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8331650

1. FOR
STATE
REGISTRAR

Coreda

REG. NO.

| | | | | | | |
|--|--|---|--|--|---------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) Cordelia Spriggs | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-15-83 | | 2b. HOUR MIN. 1752 | |
| 3. SEX F | | 4. RACE Neg | | 5. DATE OF BIRTH MONTH DAY YEAR 10 6 93 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 90 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Calvert City Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. |
| 10. CITY OR TOWN OF DEATH Lothian | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 297 W. Bayfront Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Lothian | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Fisher | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha HARVEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. -- |
| 17. INFORMANT James Spriggs | | ADDRESS 297 W. Bayfront Rd. Lothian, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ASCVD. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Cerebral Arteriosclerosis

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-18 , 19 77 , to 12-15 , 19 83 , that (I) (we) lost saw the deceased alive on 12-9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE William P. Jones MD | | | | DEGREE MD | | 22c. DATE SIGNED 12-15-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Jones | | | | 22e. ADDRESS 4837 Solomon Isl Rd 20711 | | | |

| | | | | | | | |
|--|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 18-83 | | 23c. NAME OF CEMETERY OR CREMATORY Spriggs Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Jewell Anne Arundel Md. | |
| 24. FUNERAL DIRECTOR NAME Spencer E. Sewell | | | | ADDRESS Box 31, Prince Frederick, Md. | | | |

DATE REC'D. BY REGISTRAR 19 1983
REGISTRAR'S SIGNATURE **John J. Canine**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

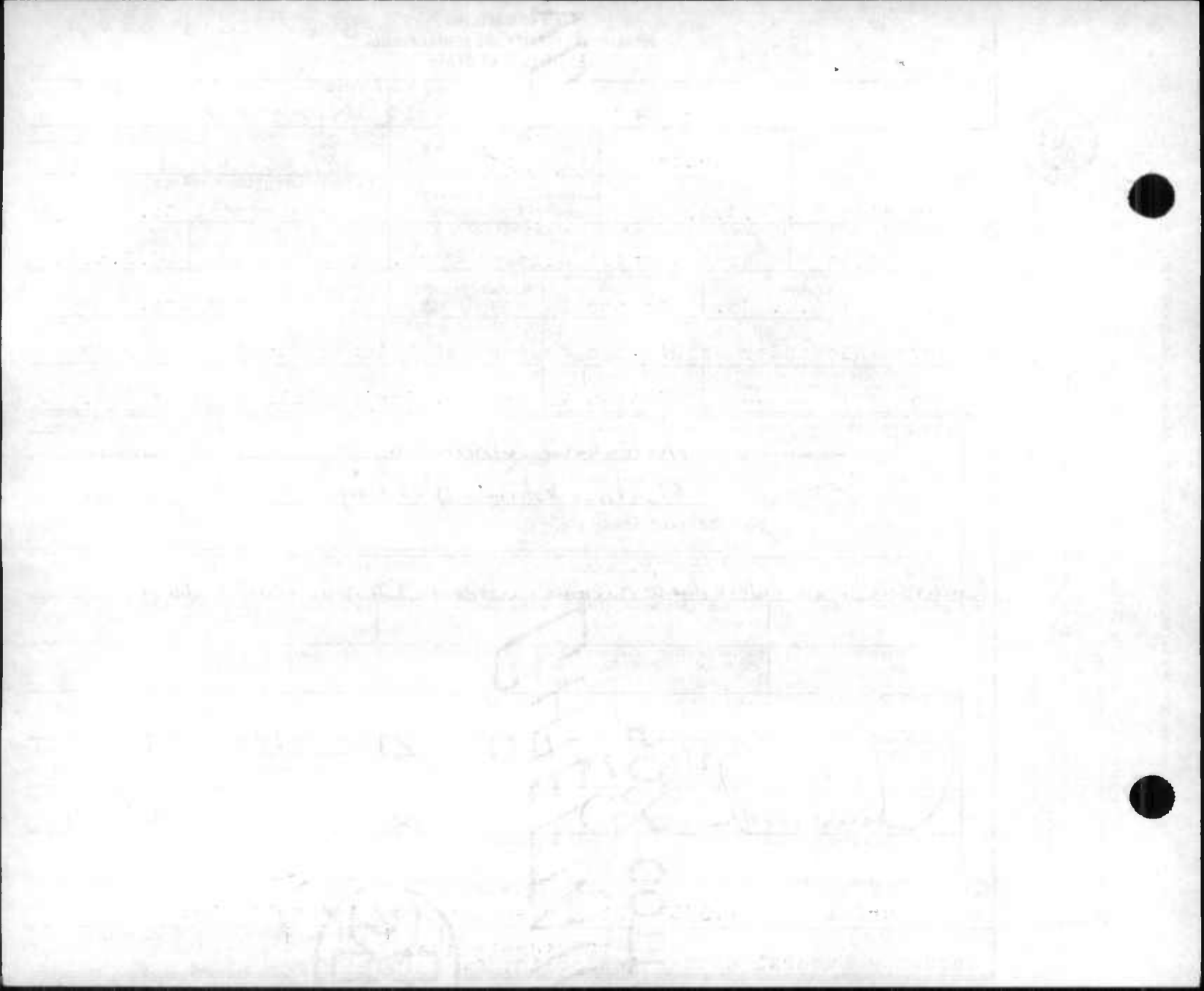
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 1 5 5 7

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lawrence Anthony Springfield | | | | 2a. DATE OF DEATH MONTH December DAY 11 YEAR 1983 | | | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH MONTH June DAY 26 YEAR 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Benedict Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) chaffeur | | 12b. KIND OF BUSINESS OR INDUSTRY U.S.N.A. | |
| 13a. STATE Md. | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 718 Monterey Ave. 21401 | |
| 14. FATHER'S NAME FIRST George MIDDLE Alexander LAST Washington Springfield | | | | 15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Laurie LAST Hurley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT ADDRESS Mary E. Springfield same as 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5728 IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic hepatic failure due to Laennec's cirrhosis, Chronic renal failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/8 19 83 to 12/11 19 83 , that (I) (we) last saw the deceased alive on 12/11 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/11/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery | | 23d. LOCATION CITY OR TOWN Annapolis, Md. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Fuenral Home | | | | ADDRESS 12 Ridgely Ave Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | EST | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | HOUR | |
| NORWOOD G STALLINGS | | | | DECEMBER 12, 1983 | | 700 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | |
| Male | | White | | MONTH DAY YEAR | | IF UNDER 1 YEAR | |
| | | | | April 4 1907 | | 76 | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | USA | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | ANNE ARUNDEL COUNTY MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Farmer | | Self Own Farm | |
| 13a. USUAL RESIDENCE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Anne Arundel | | Annapolis | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 17. INFORMANT | |
| Joseph Stallings | | UNKNOWN | | NO (YES, NO OR UNKNOWN) | | Norwood G. Stallings Jr. Same as #13 | |
| 18. CAUSE OF DEATH | | 19. SOCIAL SECURITY NO. | | 20. DATE OF OPERATION | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| PART I. DEATH WAS CAUSED BY: | | Unknown | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22. AUTOPSY? | |
| IMMEDIATE CAUSE (a) <u>5070</u> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 23. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| (b) <u>Cardiac Fibrillation</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) <u>Aspiration Pneumonia</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 24. ACCIDENT WAS UNDERLYING | | 25. TIME OF INJURY | | 26. HOW INJURY OCCURRED | | 27. DATE SIGNED | |
| OR CONTRIBUTING CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 12-7-83 | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | P.M. 19 | | | | 12-12-83 | |
| 28. INJURY OCCURRED | | 29. PLACE OF INJURY | | 30. LOCATION | | 31. DATE SIGNED | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | 12-12-83 | |
| 32. I certify that (I) (this hospital) attended the deceased from 12-7-83 to 12-12-83, that (I) (we) lost saw the deceased alive on 12-8-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 33. SIGNATURE | | 34. DEGREE | | 35. ATTENDING PHYSICIAN | | 36. MEDICAL STAFF | |
| Paul S. Rhodes | | M.D. | | <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 37. PHYSICIAN'S NAME | | 38. ADDRESS | | 39. DATE REC'D. BY REGISTRAR | | 40. REGISTRAR'S SIGNATURE | |
| PAUL S. RHODES, M.D. | | 1667 CROFTON CENTER | | JAN 19 1983 | | John J. Canfield | |
| 41. BURIAL, CREMATION, REMOVAL | | 42. DATE | | 43. NAME OF CEMETERY OR CREMATORY | | 44. LOCATION | |
| Cremation | | Dec. 15 1983 | | Cedar Hill Cem | | Baltimore P G Maryland | |
| 45. FUNERAL DIRECTOR | | | | | | | |
| Rausch Funeral Home 20734 | | | | | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

RECEIVED
JAN 10 1917

OFFICE OF THE CHIEF OF BUREAU

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 31659 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elwood Ray Stambaugh, Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 3 19 83 | |
| 3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR Sept. 18 1958 25 6. AGE (IN YEARS) MONTHS DAYS HOURS MIN. 25 | | | | | | | | | | 2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 3 19 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wettysburg, Pa. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maitenance-Westinghouse | |
| 13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster | | | | | | | | | | 13d. STREET ADDRESS 21157 2732 Littlestown Pike | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elwood Ray XXXX Stambaugh Sr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Weishaar Cullison | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No m 16b. SOCIAL SECURITY NO. 219-68-8969 | | | | | | | | | | 17. INFORMANT ADDRESS Shirley w. Cullison same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8902 IMMEDIATE CAUSE (a) Smoke and soot inhalation & Carbon monoxide intoxicication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:06 PM 12 3 19 83 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) House fire | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1924 Norwich Rd. Glen Burnie A.A. Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> TITLE (SPECIFY) M.D. Deputy Chief | | | | | | | | | | DATE SIGNED 12/4/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 12-6-83 23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md. | |
| 24. FUNERAL DIRECTOR NAME Thomas D. Fletcher 25. BY REGISTRAR DEC 7 1983 25b. REGISTRAR'S SIGNATURE <i>John J. Cullison</i> | | | | | | | | | | | |

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U.S. GOVERNMENT PRINTING OFFICE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 83 31660 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 28 83 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Theresa Kathleen Tabor</i> | | | | 2b. HOUR 5:38 PM | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>CAUC.</i> | | 5. DATE OF BIRTH MONTH DAY YEAR 1 31 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>DUBLIN IRELAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>ANNE ARUNDEL</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>CROFTON</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CROFTON CONVALESCENT CENTER</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>COLLEGE PROFESSOR</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Education</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD.</i> COUNTY <i>A.A.</i> CITY OR TOWN <i>ANNAPOLIS</i> | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS <i>660 AMERICANA DR. APT. 26</i> | | | |
| 14. FATHER'S NAME FIRST <i>Edward T.</i> MIDDLE <i>Kelly</i> LAST <i>Kelly</i> | | 15. MOTHER'S MAIDEN NAME FIRST <i>Theresa Kathleen</i> MIDDLE <i>Kelly</i> LAST <i>Kelly</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OF UNKNOWN) <i>No</i> (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO. <i>579-44-4619</i> | | 17. INFORMANT ADDRESS <i>P.O. Box 60633 Sunnyvale, CA. 94088</i> | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left Ventricular failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>4409</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/6</i> 19 <i>83</i> to <i>12/28</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12/28</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Max C Frank</i> DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>12/28/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MAX C FRANK</i> | | 22e. ADDRESS <i>7575 Rutledge Hwy Glen Burnie MD 21061</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | 23b. DATE <i>12/29/83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland P.G. MD.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Taylor Funeral Chapel</i> ADDRESS <i>ANNAPOLIS, MD.</i> | | 25a. DATE RECD. BY REGISTRAR <i>JAN 3 1984</i> | | | | | |

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Item 13a
12/29/83

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

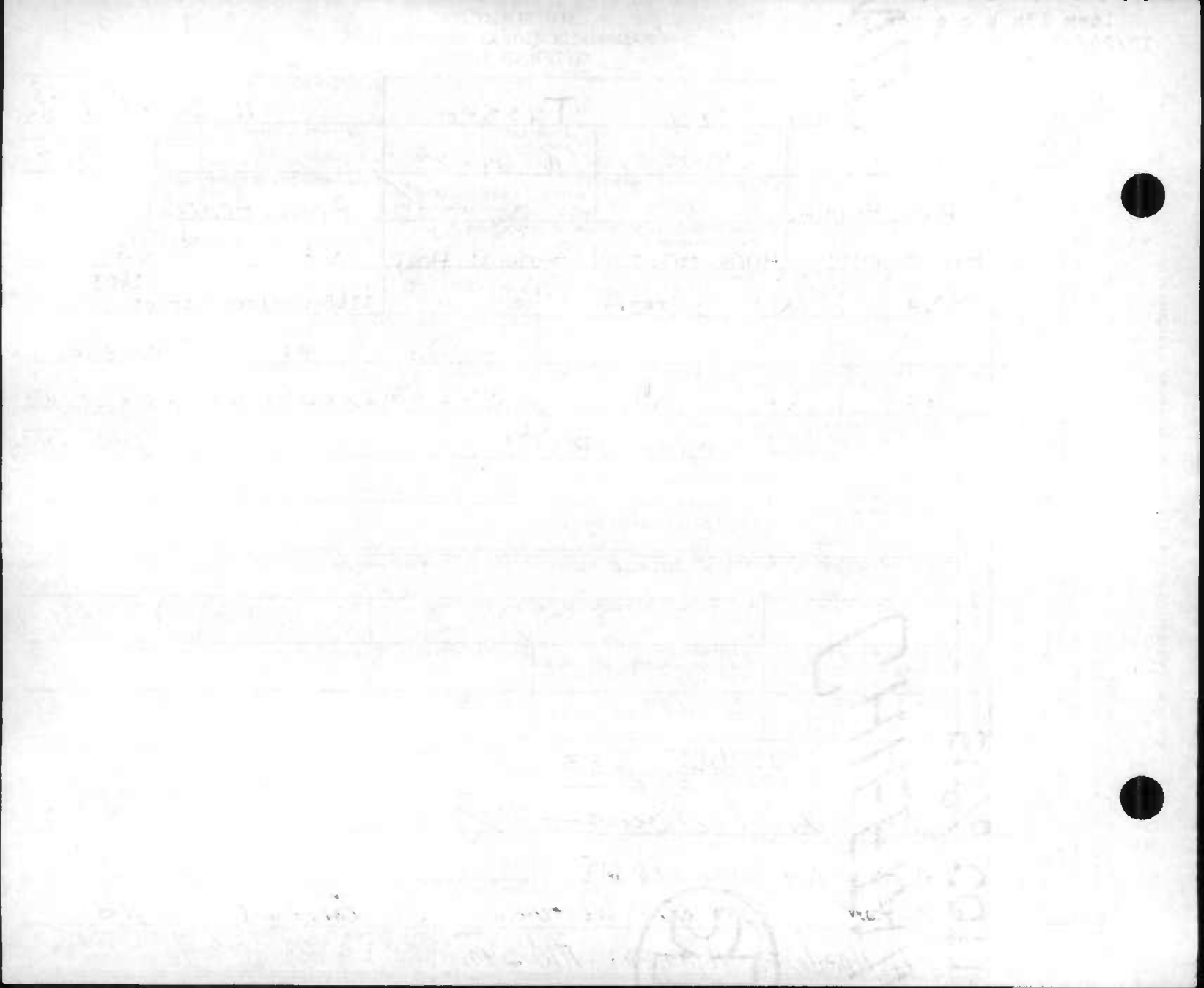
| | | | | | | | |
|--|--|--|---|---|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Baby Boy Tasker | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-24-83 | | 2b. HOUR 1:48 PM | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11-24-83 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2 8 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Anne Arundel | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA | | 12b. KIND OF BUSINESS OR INDUSTRY NA | |
| 13a. STATE MD | | 13b. COUNTY ANNA | | 13c. CITY OR TOWN ANNA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDNA | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA M. TASKER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NA | | 16b. SOCIAL SECURITY NO. NA | |
| 17. INFORMANT 1185-2 - MADISON ST ANNAPOLIS MD 21403 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7651 IMMATUREITY DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS 8 MIN | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 24 Nov 1983 , to 19 83 , that (I) (we) lost the deceased alive on 24 Nov 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Sherman Robinson MD | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/24/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHERMAN ROBINSON MD | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12-7-83 | | 23c. NAME OF CEMETERY OR CREMATORY Westview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. | |
| 24. FUNERAL DIRECTOR NAME T. A. Hagedorn | | ADDRESS Annapolis MD 21401 | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8331662

1- FOR
STATE
REGISTRAR

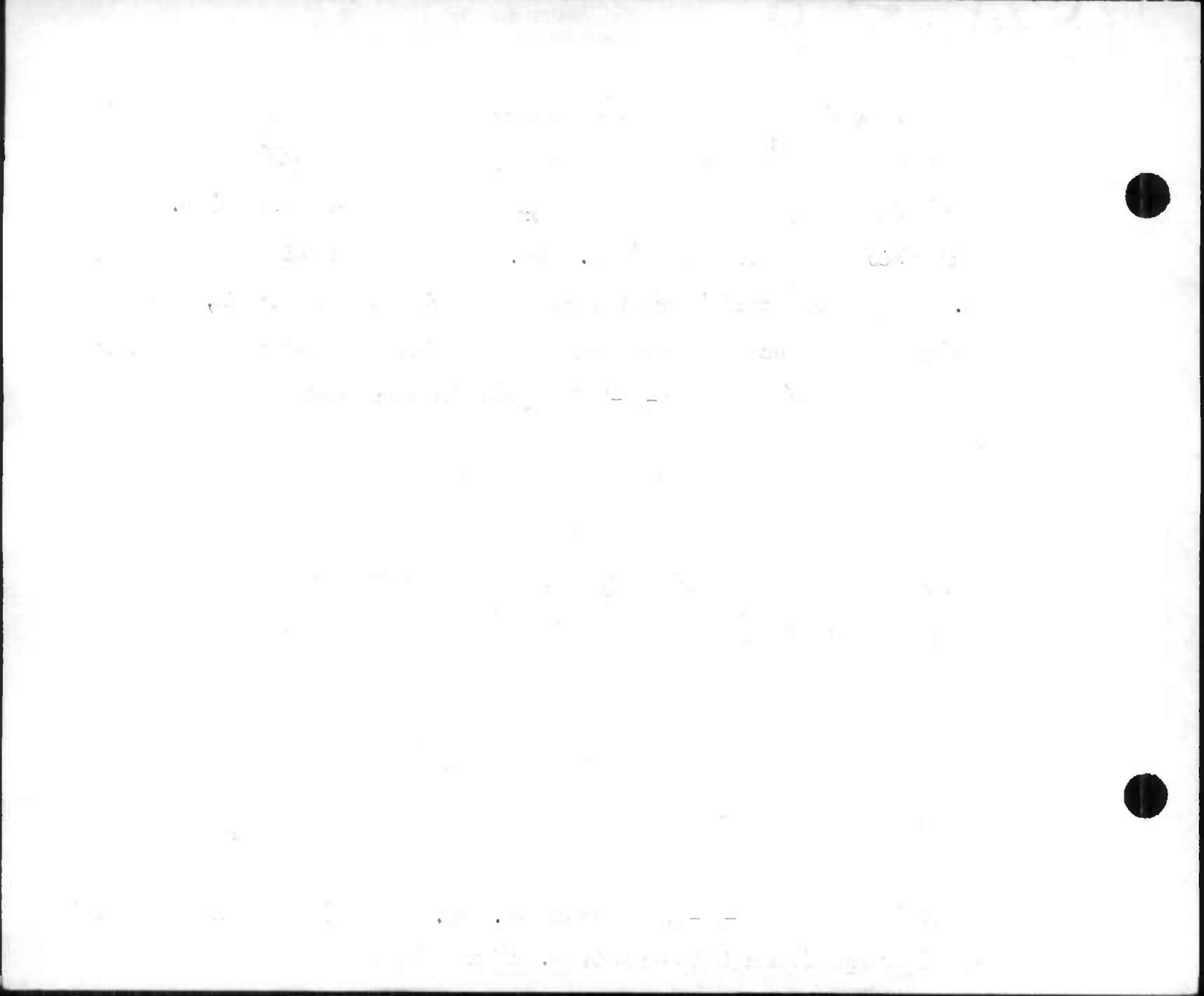
REG. NO.

| | | | | | | |
|--|-----------------------------|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY L. THOMPSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-24-83 | | 2b. HOUR 6:20 PM | |
| 3. SEX 1 MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 9-15-88 | | 6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist | | |
| 13a. STATE MD. | | 13b. CITY OR TOWN Severna Park | | 13c. STREET ADDRESS / ZIP CODE 280 Laguna Cir, 21146 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Hock Thompson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Yoden Landis | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 259-32-5352 | | 17. INFORMANT ADDRESS John Thompson same as 13 E | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy 5191 DUE TO, OR AS A CONSEQUENCE OF (b) Tracheal obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Aspiration of food | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: General atherosclerosis, Diabetes mellitus, Heart failure | | | | | | |
| 19a. DATE OF OPERATION December 14, 1983 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of left foot | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from November 83 to December 24 83 , that (I) (we) last saw the deceased alive on December 24 1983 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | |
| 22b. SIGNATURE Charles W. Kinzer | | | | 22c. DATE SIGNED Dec 25, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-29-83 | | 23c. NAME OF CEMETERY OR CREMATORY Wasatch Mem. Pk. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Salt Lake City Utah | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE John J. Connel | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mc Cully Funeral Home 3204 Mountain Rd. 21122 | | | | 25. DATE REC'D. BY REGISTRAR | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other" it shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR
FOR THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR THE
FURNACE. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE
MEDICAL EXAMINER. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL

DHMH - 17
(VR A15 ME (5))
20M 4/82

| FOR STATE REGISTRAR | | ELEANOR S. TOMCHUK DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. |
|--|-------------------------|---|--|---|--|----------|
| 1. DECEASED NAME (TYPE OR PRINT) Eleanor S. Tomchuk | | 2c. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 12 29 83 | | 2d. HOUR 2158 | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7 11 24 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 59 RS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD 12 29 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Line | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL | | 12b. KIND OF BUSINESS OR INDUSTRY Md Paper Box | | | | |
| 13a. STATE Md | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stanley Gregoryk | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie R. Rycharski | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-18-4521 | | 17. INFORMANT ADDRESS Natalie O'Dea 5403 McNairy Road Greensboro, NC 27405 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC Arrest | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | |
| Untreated Hypertension | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | |
| ACTUAL SIGNATURE William P. Jones | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | DATE SIGNED 12-30-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | ADDRESS 695 America Ct. Davidsonville 21035 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-3-84 | | 23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Pk | | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce | | ADDRESS 4001 Ritchie Hwy Balto Md | | 25. REGISTRAR'S SIGNATURE [Signature] | | |

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Handwritten notes and signatures, including the name "William F. Johnson" and various illegible entries.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR 15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|-------------|---|---|--|--|--|--|
| 1- FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Peter W. TRAYNOR | | 2b. DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR 12 15 83 | | 2c. HOUR M 12 | |
| 3. SEX M | 4. RACE CAU | 5. DATE OF BIRTH MONTH DAY YEAR 4 13 17 66 | 6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 17 83 | 7d. HOUR M 12 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A. F. Co. MD. | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 420 F Secluded Post Cir | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES, Retail | | 12b. KIND OF BUSINESS OR INDUSTRY WARD | |
| 13a. STATE Md. | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 420 F Secluded Post Cir | | 14. FATHER'S NAME FIRST MIDDLE LAST Peter W. TRAYNOR | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIA D STRINER | | ADDRESS 5811 C Wilburton Ave Bkto MD 21239 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WW II 22010114 | | 17. INFORMANT RUTH TRAYNOR | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIAC Arrest. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE William P. Jones, M.D. | | TITLE (SPECIFY) Deputy | | MEDICAL EXAMINER | | DATE SIGNED 12-18-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | ADDRESS 695 America Court | | 21035 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/20/83 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND Alle. MD. | |
| 24. FUNERAL DIRECTOR NAME Robert A. Banana | | ADDRESS Severna Park, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE Sam J. Conrad | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR Item 19b & 22a 3-14-84 cn | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | | EST | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|----------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEARL TYLER | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 09, 1983 | | | | 2b. HOUR 0214 PM | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 15 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE md | | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Severn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7637 WB+A Rd | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Lambrell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Dorsey | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-28-3890 | | 17. INFORMANT ADDRESS Alice Lambrell - 7637 WB+A Rd | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 2773 DUE TO, OR AS A CONSEQUENCE OF: (b) (Amyloidosis) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertension (unknown etiology) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 year 8 months | | | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Severe loss of weight | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 5/26/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cervical node biopsy Bronchoscopy | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Paul J. Chang | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/9/83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL J. CHANG, M.D. | | | | 22e. ADDRESS 801 CRAIN HIGHWAY, S.E. GLEN BURNIE, MARYLAND, 21061 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 12-14-83 | | 23c. NAME OF CEMETERY OR CREMATORY ST Rest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA Md | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Turnell B. Oden | | | | ADDRESS Balto. Md | | 25. DATE RECD. BY REGISTRAR DEC 12 1983 | | REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

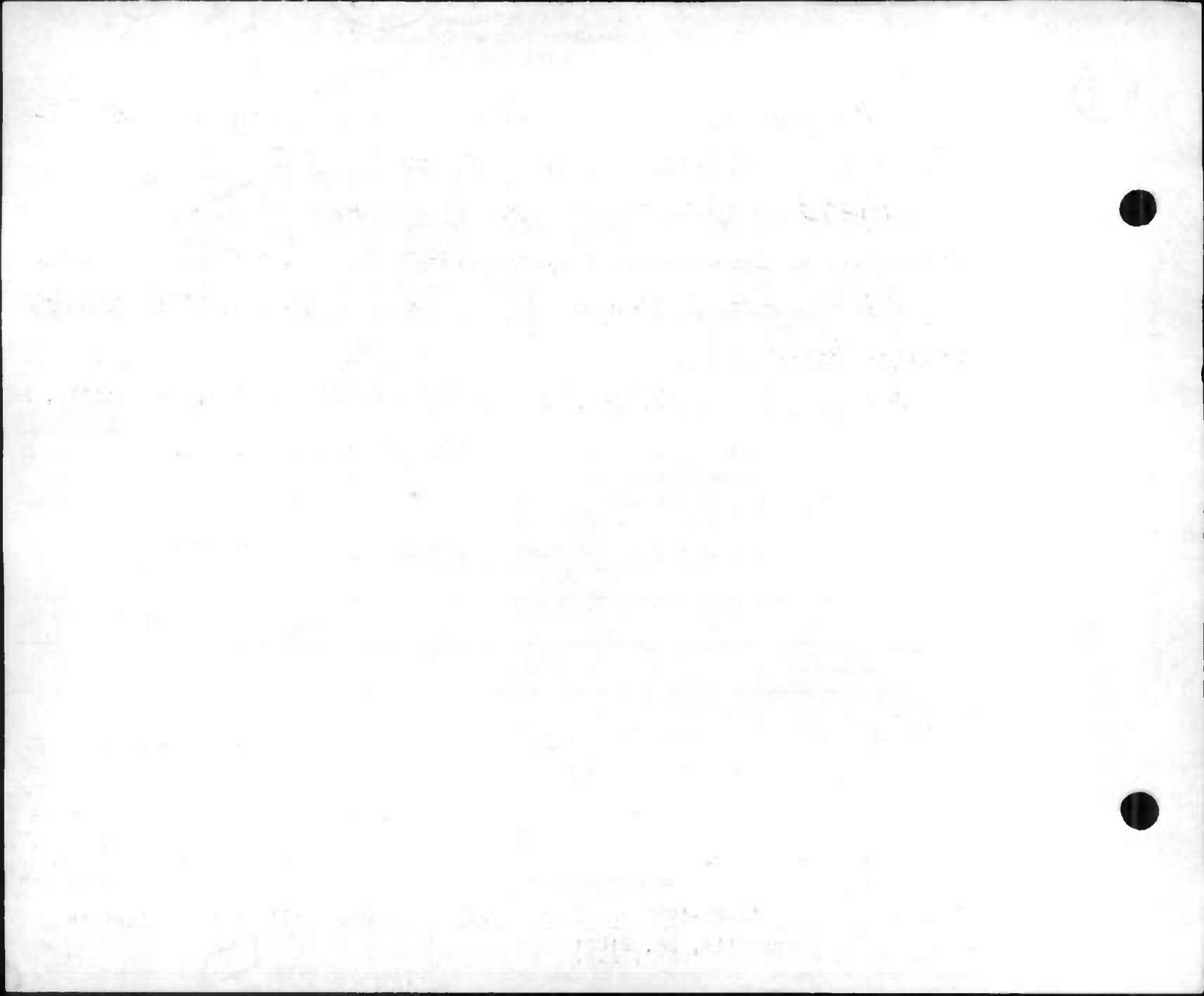
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marguerite Villa</i> | | | 2a DATE OF DEATH MONTH DAY YEAR <i>December 22 1983</i> | | 2b HOUR <i>7¹⁵ AM</i> | |
| 3 SEX <i>Female</i> | 4 RACE <i>White</i> | 5 DATE OF BIRTH MONTH DAY YEAR <i>11 8 98</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | 7b CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD | | |
| 10 CITY OR TOWN OF DEATH <i>Crownsville</i> | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Crownsville Hospital Center</i> | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>NONE</i> | | 12b KIND OF BUSINESS OR INDUSTRY <i>NONE</i> | |
| 13a STATE <i>MD</i> | | 13b COUNTY <i>AA</i> | 13c CITY OR TOWN <i>Deale</i> | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>George Mosher</i> | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b SOCIAL SECURITY NO. <i>500-12-6713</i> | | 17 INFORMANT ADDRESS <i>CROWNVILLE HOSPITAL CENTER, Crownsville, Md</i> | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory failure</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASH-CVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>7-8</i> , 19 <i>68</i> , to <i>12-22</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12-16</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE <i>S. EREN</i> | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <i>12-22-83</i> | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. EREN</i> | | 22e ADDRESS <i>Crownsville hospital center</i> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b DATE <i>12-27-1983</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATIONAL CEME.</i> | | |
| 23d LOCATION CITY OR TOWN COUNTY STATE <i>Arlington Virginia</i> | | 25a DATE REC'D. BY REGISTRAR <i>JAN 4 1984</i> | | | | |
| 24 FUNERAL DIRECTOR <i>WILLIAM REESE & SONS MORTUARY, P.A.</i> | | 25b REGISTRAR'S SIGNATURE <i>James G. Conner</i> | | | | |

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DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) OTTO Von Schader R | | | | | | 2a. DATE OF DEATH MONTH 12 DAY 22 YEAR 88 | | | | 2b. HOUR 11:15 P.M. | |
| 1. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH Dec. DAY 1 YEAR 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 95 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Edgewater | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Con.Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN Arnold | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 350 Freshfield Lane | | | |
| 14. FATHER'S NAME FIRST John MIDDLE Von Schnader LAST Sophia | | 15. MOTHER'S MAIDEN NAME FIRST Sophia MIDDLE Ditzel LAST Ditzel | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORATES) 166-10-9494 | | 17. INFORMANT ADDRESS 344 Freshfield La. MD 21012 Doris Fordham-Arnold | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE Heart Failure 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| NONE | | | | | | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A. | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input checked="" type="checkbox"/> N/A | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | 21f. LOCATION STREET N/A CITY OR TOWN N/A COUNTY N/A STATE N/A | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16 19 83 , to 12/22 19 83 , that (I) (we) last saw the deceased alive on 12/16 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Thomas Walsh MD | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS M. WALSH, MD | | | | | | 22e. ADDRESS 269 Peninsula Farm Road ARNOLD MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION CITY OR TOWN Balto. COUNTY Balto STATE MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 28 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Casper | | | |

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DHMH-16-30M 2/80
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CATHERINE B. WALLACE | | | 2a. DATE OF DEATH MONTH DAY YEAR DEC. 25 1983 | | 2b. HOUR 11:30AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 6 1915 | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sectry. | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | |
| 13a. STATE Maryland | | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Shady Side | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST John -- Buscher | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette -- McLaughlin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -- -- 579 18 0764 | 17. INFORMANT Husband David H. Wallace ADDRESS Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Line B should be HYPERTENSIVE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 3 Years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Viral Bronchitis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 16</u> , 19 <u>80</u> , to <u>Dec. 25</u> , 19 <u>83</u> , that (I) (we) lost <u>saw the deceased alive on Dec. 24</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>E. Stuart Lyddane</u> | | DEGREE <u>M.D.</u> | | 22c. DATE SIGNED Dec. 26 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Stuart Lyddane M.D. | | 22e. ADDRESS 3066 Q Street, N.W./Wash. D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE Dec 28, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia |
| 24. FUNERAL DIRECTOR DeVol Funeral Home/ 2222 Wisc. Ave. <u>Robert A. DeVol</u> ADDRESS Washington D.C. | | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> |

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth D. Webb | | | 2a. DATE OF DEATH MONTH 12 DAY 2 YEAR 83 | | 2b. HOUR 0830 AM |
| 3. SEX Female | 4. RACE Can | 5. DATE OF BIRTH MONTH AUG DAY 6 YEAR 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | |
| 10. CITY OR TOWN OF DEATH Anne Arundel Co. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KIMBROUGH ARMY COMMUNITY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY XXXXXXX |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Stephen MIDDLE Joseph LAST Lester DuLaney | | 15. MOTHER'S MAIDEN NAME FIRST Cora MIDDLE Woodward LAST Anderson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 579-32-5774 | | 17. INFORMANT ADDRESS Daughter - 1124 Indian River Landing Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Small cell Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 yr |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): NONE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS INVOLVED <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 28 NOV 83 19 83 to 2 DEC 83 19 83 , that (I) (we) lost saw the deceased alive on 2 DEC 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death. | | | | | |
| 22b. SIGNATURE Kenneth Melton, MD | | DEGREE MD | | 22c. DATE SIGNED 2 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH MELTON | | 22e. ADDRESS USA MEDDAC FGGM | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 12-6-83 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. | |
| 23d. LOCATION Arlington Va. | | STATE | | | |
| 24. FUNERAL DIRECTOR NAME T.A. Hardesty | | ADDRESS Annapolis Maryland | | 25a. DATE REC'D. BY REGISTRAR DEC 5 - 1983 | |
| 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | |

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DEC 6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | EST | |
|--|--|--|--|---|--|---|--|--|--|--|--|-----|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM GARLAND WHETZLAR | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 04 1983 | | | | 2b. HOUR 0719 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | IF UNDER 1 YEAR MONTHS DAYS 00 00 | | IF UNDER 24 HRS. HOURS MIN. 00 00 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard | | 12b. KIND OF BUSINESS OR INDUSTRY Westinghouse | | | | | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 659 N. Riverside Dr. 21122 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Whetzlar | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alliquappa Williams | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II | | 17. INFORMANT (wife) Mrs. Rosemary Whetzlar | | ADDRESS Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 2500 DUE TO, OR AS A CONSEQUENCE OF: (b) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Diabetes mellitus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Unknown Unknown | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) the hospital attended the deceased from 8-21 , 19 72 , to 11-22 , 19 83 , that (I) the Just saw the deceased alive on 11-22 , 19 83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) we did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Arthur Lankeford Jr. MD | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-5-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR LANKEFORD MD | | | | | | 22e. ADDRESS 2934 MOUNTAIN RD PASADENA MARYLAND 21122 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8 Dec. 83 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. Glen Burnie A.A. Md. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME Dean P. Charlton ADDRESS Singleton Funeral Home Glen Burnie Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 6 1983 | | 25b. REGISTRAR'S SIGNATURE John J. [Signature] | | | | | |

MEDICAL CERTIFICATION

REC 0300 10/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8331671

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT S. WIER | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-10-83 | | | 2b. HOUR 2:31 AM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 5-2-11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co MD. | | | |
| 10. CITY OR TOWN OF DEATH SEVERNA PK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 209 GIDDINGS RD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR | | 12b. KIND OF BUSINESS OR INDUSTRY ELECTRIC WESTERN | |
| 13a. STATE MD | | 13b. COUNTY A.A. Co | | 13c. CITY OR TOWN SEVERNA PK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 209 GIDDINGS RD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert M Wier | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FRANCES SCHENKEL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216032902 | | 17. INFORMANT ADDRESS WANNITA R. WIER - ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF: (c) Arterio sclerotic Heart Disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Donald A. Hefley | | | | | | 22c. DATE SIGNED | | 22d. ADDRESS | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22f. ADDRESS | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTO MD. | |
| 24. FUNERAL DIRECTOR NAME Robert S. Baranco ADDRESS Severna Park, Md | | | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

BP _____

Report of the
Commissioner of Plant Industry
for the year 1904

Washington, D. C.
1905



20% OFFICIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | JUNE 8 1983 REG. NO. 31072 | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT S. WILLIAMS | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-6-83 | | 2b. HOUR 12 PM |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 10-27-23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A-A Co MD. | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A-A GEN. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES | 12b. KIND OF BUSINESS OR INDUSTRY PLASTICS MEDICAL |
| 13a. STATE MD | 13b. COUNTY AA | 13c. CITY OR TOWN SEVERNA PARK | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 445 CROXTON CT. 21146 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William F WILLIAMS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH STEWART | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 026 12 4217 | | 17. INFORMANT ADDRESS WIFE - JEAN LEITH WILLIAMS ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1b, stating the underlying cause last: (b) Chronic lung disease and DUE TO, OR AS A CONSEQUENCE OF (c) Cor Pulmonale & lower extremities APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1b | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED - WHILE AT WORK <input type="checkbox"/> - NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 75 to 6/12/83 19 83 , that (1) (my) last saw the deceased alive on 5/12/83 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (I) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John V. Lowe | | DEGREE MD | | 22c. DATE SIGNED 6/12/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Lowe | | 22e. ADDRESS ANNAPOLIS MD 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) CREMATION | | 23b. DATE 12/6/83 | 23c. NAME OF CEMETERY OR CREMATORY Westview Crem | | 23d. LOCATION (ID OF TOWN) Westview Bardo Md. |
| 24. FUNERAL DIRECTOR NAME Robert S. Benancio | | ADDRESS Severna Park | | 25. FILED BY REGISTRAR OR REGISTRAR'S SIGNATURE DEC 9 1983 John J. Carver | |

BP

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text appears to be organized in a list or table format with multiple columns and rows.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31673

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary V. Willson | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-16-83 | | | | 2b. HOUR 6:15 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10-31-24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Underwriter | | 12b. KIND OF BUSINESS OR INDUSTRY Insurance | |
| 13a. STATE MD | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Harwood | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2071b 4480 Muddy Creek Rd | |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. Elmer Stokes | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadelia Harrison | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT Leonard Willson | | | | ADDRESS Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 2 weeks APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple Myeloma ; COPD | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/28 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12/16 83 | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 11/28 83 to 12/16 83 , that (2) I saw the deceased alive on above date and that (3) I did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ernest W. Cole III | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/16/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E W COLE III | | | | 22e. ADDRESS 51 FRANKLIN ST ANNAP MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 19, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Lakemont | | 23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville AA MD | | | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD | | | | 25a. DATE REC'D. BY REGISTRAR DEC 20 1983 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Sam J. Grier | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRANCIS MARKHAM WINGATE | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-1-83 | | 2b. HOUR 2 a M |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 8-19-16 | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wingate Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co MD. | | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) school teacher education | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY A.A. Co. 13c. CITY OR TOWN Lothian | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 76 Owensville Rd. 20711 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Millard Meade Wingate | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cornelia Aurillia McNamara | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 213-14-1363 | 17. INFORMANT ADDRESS Bonnie P. Wingate 76 Owensville Rd. Lothian Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung Cancer 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/23 P.M. 19 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 51 FRANKLIN ST. ANNAPOLIS Md. | |
| 22a. I certify that (1) this hospital attended the deceased from 11/23 , 19 83 , to 12/1 , 19 83 , that (1) (we) lost saw the deceased alive on 11/30 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Ernest W. Coleman | | DEGREE MD | | 22c. DATE SIGNED 12/1/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EW COLE III | | 22e. ADDRESS 51 FRANKLIN ST. ANNAPOLIS Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/4/83 | | 23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE West River, Md. | | 23e. DATE REC'D. BY REGISTRAR 12/06/83 | | | |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home | | ADDRESS 12 Ridgely Ave. Annapolis, Md. | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 5 7 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PETER S. WINTERS | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 12 83 | | 2b. HOUR 11:50 P.M. |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 12 20 14 | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY MOTOR PATTERNS |
| 13a. STATE MARYLAND | | | 13b. COUNTY ANNE ARUNDEL | 13c. CITY OR TOWN ARNOLD | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST PETER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANTOINETTE (UNKNOWN) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 284-10-6296 | | 17. INFORMANT ADDRESS HELEN H. WINTERS (SAME AS 13) | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **probable adenocarcinoma of the GI tract** 1599
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Cancer of the prostate

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from about 12/12 1983 to 12/12 1983 , that (1) (we) lost saw the deceased alive on 12/12 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.) | | | |
| 22b. SIGNATURE James Chaconas M.D. | | 22c. DATE SIGNED 12/12/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Chaconas | | 22e. ADDRESS 1521 Ritchie Hwy Arnold, Md | |

| | | | |
|--|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | 23b. DATE 12-16-83 | 23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BALTIMORE MD |
| 24. FUNERAL DIRECTOR NAME Robert Baron | | 25a. DATE REC'D. BY REGISTRAR DEC 16 1983 | |
| ADDRESS Forever Park Fun Home | | REGISTRAR'S SIGNATURE John J. Carver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal officer must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 1 6 7 6

1 - FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRTLE LARENE WISE | | | 2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 1, 1983 | | 2b. HOUR 10:00A |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Jan 1 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Altoona Pa. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Md. | 13b. COUNTY A.A. | 13c. CITY OR TOWN Odenton | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 546 Rita Dr. 21113 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H. Snyder | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Limebaugh | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 211-18-4796 | | 17. INFORMANT (daughter) ADDRESS Mrs. Virginia Sherman Same As 13 | |

| | | | | | |
|--|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 4275 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (c) Chronic heart failure | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) chronic renal failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE BK | | DEGREE MD | | 22c. DATE SIGNED 12/1/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHANDELWAL, M.D. | | 22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6 Dec. 83 | | 23c. NAME OF CEMETERY OR CREMATORY Blair Memorial Pk | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Bellwood Blair Md | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE DEC 6 1983 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home Glen Burnie Md. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Paper may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STAIN-RESISTANT

20% COTTON

DEC 8 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST FREDERICK | | MIDDLE Lee | | LAST Woolford Sr. | | 2a. DATE OF DEATH MONTH DAY YEAR 12-21 83 | | 2b. HOUR 354 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb 12, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cobbler | | 12b. KIND OF BUSINESS OR INDUSTRY USNA | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Annapolis | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 114 Roselawn Rd. 21403 | | | |
| 14. FATHER'S NAME Harrison Alexander Woolford Sr. | | | | | | 15. MOTHER'S MAIDEN NAME Mary Louise Kautz | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11 | | 17. INFORMANT Betty Woolford 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiac Arrest - DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction - DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 1/2 hrs. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21 19 83, to 12/21 19 83, that (I) (we) lost saw the deceased alive on 12/21 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard A. Kautz MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 12/21/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE 12-23-83 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME T.A. Hardesty | | | | | | ADDRESS Annapolis Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canine | |

BP

RECEIVED
JAN 11 1971
FBI - NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 31678

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) RICHARD Wuestefeld | | 2a. DATE OF DEATH MONTH DAY YEAR 12 31 83 | | 2b. HOUR 8 AM | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR March 2, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Ret.) | | 12b. KIND OF BUSINESS OR INDUSTRY Food Service |
| 13a. STATE MD | | 13b. COUNTY AA | 13c. CITY OR TOWN Arnold | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Charles Wuestefeld | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Meta Wittekindt | | 16. ADDRESS 137 Holly Drive North Annapolis MD 21401 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 096-05-6717 | | 17. INFORMANT Gertrude W. Knopfle | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 ACVD DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION 30 December 1983 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ACVD | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 30 December 1983 to 30 December 1983 , that (I) (we) last saw the deceased alive on 30 December 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Philip M. Neustadt, MD | | DEGREE MD | | 22c. DATE SIGNED 12/31/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip M. Neustadt, MD | | 22e. ADDRESS Promedical Emergency Care Center 530 College Park Drive Annapolis, Maryland 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Jan 2, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD | | 23e. DATE REC'D. BY REGISTRAR JAN 4 1984 | | | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD | | 25a. REGISTRAR'S SIGNATURE John J. Ganiel | | | |

BP _____

1. The first part of the paper is devoted to a general
 discussion of the problem. It is shown that the
 problem is of great importance and that it has
 not been completely solved. The author then
 presents a new method for solving the problem.
 This method is based on the use of the
 principle of least squares. It is shown that
 this method is more accurate than the
 methods previously used. The author then
 applies this method to the solution of the
 problem. It is shown that the results are
 in good agreement with the experimental
 data. The author then discusses the
 advantages of this method and its
 applications.

2. The second part of the paper is devoted to a
 detailed discussion of the method. It is shown
 that the method is based on the use of the
 principle of least squares. It is shown that
 this method is more accurate than the
 methods previously used. The author then
 applies this method to the solution of the
 problem. It is shown that the results are
 in good agreement with the experimental
 data. The author then discusses the
 advantages of this method and its
 applications.

3. The third part of the paper is devoted to a
 discussion of the results. It is shown that the
 results are in good agreement with the
 experimental data. The author then discusses
 the advantages of this method and its
 applications.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|-------------------------|--|--------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AIDA CECELIA YOUNG | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR December 16, 1983 | | 2b. HOUR 8:00 | | A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4-9-1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 62 | | IF UNDER 24 HRS. HOURS MIN. 62 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Linthicum | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 611 Cleveland Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY A. A. | | 13c. CITY OR TOWN Linthicum | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 611 Cleveland Road | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ettore = Gentile | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annunciata = Bavota | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | 16b. SOCIAL SECURITY NO. 216-12-5106 | | 17. INFORMANT ADDRESS Mary F. Wirsching 611 Cleveland Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 2030 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCT 15 , 19 82 , to DEC 15 , 19 83 , that (we) last saw the deceased alive on 12-12 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Raymond J. Donovan, Jr. | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12-16-83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond J. Donovan, Jr., M.D. | | | | 22e. ADDRESS 3350 Wilkens Avenue, Balto, Md. 21229 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Raymond C. Fink Glen Burnie, Md. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | |



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